Personal Information

Primary Reason for Today's Visit? _____(Circle One) Medical /Cosmetic

Name: _____ Birth Date:_____

Street Address: _____ City: _____State: _____

Zip Code: _____ Phone: 1._____ Phone 2._____

Email Address: _____

Agree to texts/emails for all communications? (Circle One) Yes / No

Referred By? _____Personal Referral / Social Media / Website

Primary Care doctor: _____Address/Phone:_____

Emergency Contact: _____Relationship: _____ Phone: _____

Has Dr. Patel treated you previously? Y/N **; When (Date):_____ ; Where (Place/Center): _____**
For what: _____

Employer:_____

MEDICAL HISTORY (Please complete all sections)

Height:_____ft _____in Weight:_____lbs Age:_____

Allergies: Drug/latex/food allergies (please list all):_____

ARE YOU PREGNANT? _____

Current Medications (List **ALL** Meds-Prescription, Herbal, Supplements, Birth Control Pills, etc)

Medication	Dose	Frequency	Reason

Social History (Describe any usage)

Alcohol:	Circle One: Never/ Occasional/ Weekly/ Daily
Smoking/Vaping: (Amount/Time)	
Drugs:	

Surgical / Procedure History (Please also include any cosmetic surgery):

_____

Skincare History (COSMETIC PATIENTS ONLY)

Are you concerned with or do you have a history of: (Circle)

Prior or Current usage/treatment: (Circle)

Any recent tanning or sun exposure? _____

Have you had cold sores or Herpes? (Circle One) Y/N. Keloids or poor scarring history?_____

PAST MEDICAL HISTORY: Circle all that apply

Hepatitis A/B/C	HIV/AIDS	High blood pressure	Stroke
Heart Attack	Diabetes	Kidney Disease	Bleeding condition
Myasthenia Gravis	Lupus	Rheumatoid Arthritis	Dementia
Thyroid Condition	Seizures	Cancer	Vascular disease
Heart Pacemaker/AICD	Anxiety/Depression	Blood Clots	Other:

Skin infections	Large pores	Keloids/Excess scarring	Skin cancer history
Rosacea	Acne	Pigmentation	Uneven skin tone
Excess fat under chin	Wrinkles	Facial aging	LIST:

FINANCIAL POLICY:

1. For medical visits, we MUST have a copy of your current insurance card in order to file for you or your family member. If your insurance requires a referral or pre-authorization, we must have this in our office **prior** to your appointment. Patients are responsible for obtaining referrals if needed. **If a visit is denied because of lack of referral, you will be responsible for the charges. WE ARE OUT OF NETWORK WITH COMMERCIAL INSURANCES. Please verify all insurance benefits prior to the visit. This is a patient responsibility. As per state regulations, you have been make aware that we do not participate with commercial health insurance plans.**

2. **Your Insurance Policy is a contract between you and your insurance company.** We cannot guarantee to you that your insurance will pay all or any part, of your claim. **If you have any questions regarding your outstanding deductible and/or surgical co-pays, please consult your insurance company prior to scheduling surgery or visits.** Payment of services rendered to any dependent children rests with the parent who seeks treatment.

3. A $35.00 service charge will be applied to your account for all returned checks or any stopped payment on an issued check.

4. **MISSED APPOINTMENTS / CANCELLATIONS – Our policy is to charge for missed appointments or appointments cancelled with less than 48 hours notice at a rate of $59.00.** A $250 fee will be charged for any medical (non-cosmetic) surgery missed or cancelled with less than 1 week notice

5. **FORM FEE:** $25 per form that will need to be filled out by the office (FLMA, disability, work release, etc)

6. **COSMETIC SURGERY:** Please be advised that all cosmetic surgery payments must be paid in full 14 days prior to the date of operation. If you cancel your surgery with less than three (3) business days of notice in advance of the date of your surgery, you will forfeit 50% of the total surgery cost to Priti P Patel MD LLC. Certified bank checks or money order must be provided at least 2 weeks prior to the surgical date.

7. If you have requested a plastic surgeon for emergency room treatment, **you will be balance billed** if we are unsuccessful in negotiating with your insurance plan. It is a member responsibility to contact the insurance carrier and file any **member appeals** if needed. Please note that any unpaid balances will be forwarded to our collections department. You will be responsible for payment along with collections fees and interest if applicable. All insurance checks must be forwarded to our office.

INSURANCE INFORMATION: (PLEASE PROVIDE INSURANCE CARD AT VISIT). (REQUIRED FOR MEDICAL PATIENTS ONLY)

Primary Policy Holders Name: _____(Guarantor) DOB_____/_____/_____

Member ID number (group/individual):_____ Primary or Secondary (Circle One)

I hereby authorize Priti P Patel MD LLC to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and/or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits is due the day of service and if insurance submitted for surgical services is not paid by 90 days, I must pay in full unless arrangements are made. I am responsible for all referrals needed and understand that I will be billed if a visit is unpaid due to lack of needed referral documents.

Patient signature or legal representative_____Date_____

Authorization and Receipt of Financial Policy

I agree to be responsible for any medical expenses incurred with Priti P Patel MD LLC., therefore, I authorize my insurance company, attorney, or other parties to pay directly to Priti P Patel MD LLC. and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy provided and I accept responsibility for any balance not covered by my insurance company and any fees or charged incurred while being treated at this facility. WE ARE OUT OF NETWORK WITH ALL COMMERCIAL INSURANCES EXCEPT MEDICARE. Please contact your insurance for benefit details, copays/coinsurance/deductibles as this is a patient responsibility.

Patient signature (or legal representative): _____ Date:_____

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I acknowledge that a copy of Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Patient signature or legal representative_____

Permission for Photography, Videography, or Publication

I give permission for the Dr. Priti Patel and her associates or employees to take photographs/videos of me before, during, and after my treatments. As the condition creates a visual image, this image is important in the diagnosis and management of my concerns. These photographs/videos will be an important part of my medical record. These photographs may be used (*with identity protected*) for research, educational, marketing purposes, board recertification and may be published in professional medical journals or books.

I hereby voluntarily participate and give authorization to appear in filming, photographs, videotaping, and/or interviews for Priti P Patel MD LLC (Aesthetiq) for public relations and advertising. I do hereby consent to the unlimited use of such products or interviews for publications and or websites, social media, news media reports, newspapers, magazines, television or radio, or any other type of advertising. I hereby release Priti P Patel MD LLC, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product or the advertising or other copy that may be used in connection with the above. I hereby consent to the above, without expectation of renumeration to me now or in the future, and this shall be binding upon my heirs, personal representatives and assignees.

Signature: _____Date: _____

(*If you do not want your photographs/videos used for public relations and advertising, please check the box. ☐