PATIENT REGISTRATION

(Please Print)

How did you hear about us? □Billboards □Word of mouth □Yellow Pages □Doctor □Patient

□Internet (list site)_____________________________________□Other____________________________________

Date: __________ NAME: ____Nickname:___________________

Date of Birth:_________________Age:________ Sex:_______Marital Status_______ S.S. #: ______-____-_______

Address: ____

City:___________________________ State: __________ Zip Code:______________

Home Phone Number: (_____)________-___________ O.K. to leave detailed message? Yes □ No □

Cell Number: (_____)________-____________ E-mail:____

Work Number: (_____)_______-_____________O.K. to call work? Yes □ No □ Leave detailed info? Yes □ No □

Occupation:_______________________________ Place of Employment:____________________________________

Name of Spouse: _______________________________ Work Tel. No.: ____________________________________

To whom may we give medical information to: Name/Relationship:____

____

Family or Personal Physician: ____

In Case of Emergency Notify: _____________________ Relationship: ________________Tel. No:_______________

PERSON FINANCIALLY RESPONSIBLE

Name: ____ Relationship: ______________________________________

S.S. No.: _________________________ Home Tel. No.: __________________ Work Tel. No.: _________________

INSURANCE – Please give cards to receptionist if your visit/procedure is covered by insurance.

Insured's Name:______________________________ Insured's DOB:___________ Relationship_________________

Insured's SSN:___________________________ Insured's Phone No:_________________

MEDICAL HISTORY

Allergy/Reactions: ____Latex Allergy: Yes □ No □

Illnesses: Diabetes □ Heart Disease □ High Blood Pressure □ Cancer □ Kidney or Bladder Disease □

Lung Disease □ Asthma □ Liver, Stomach, or Intestinal Diseases □ Hepatitis □ Bleeding Disorder □

Poor Healing □ Keloids □ Psychiatric □ HIV Positive □ Other __________________________

Surgeries:____

Medications: (Prescription and non-prescription drugs) ____

____

Vitamins and Herbs: ____

Do you smoke? Yes □ No □ If yes, how much?_______________

Do you drink alcohol? Yes □ No □ If yes, how often?_____________________

I certify that the above is true and correct and that I have not omitted any information that would hinder my treatment or care by Dr. Butler or Dr. Leveque and his/her staff.

Signed____ Date:___________________ (over)

FINANCIAL RESPONSIBILITY

I understand that I am solely responsible for payment of cosmetic procedures. I also understand that based on the type of service scheduled, payment is required in full prior to or at the time of service.

If my services are submitted to my insurance company, I understand and agree that I am responsible for all insurance deductibles and co-payments. I will be reimbursed for any overpayments made by me. I authorize the release of any protected health information necessary to carry out treatment, payment or health care operations. I also authorize payment of medical benefits, including Medicare benefits, to Dr. Butler or Dr. Leveque, the physician rendering the services, in reimbursable amounts as stated in my contract.

Regardless of insurance or litigation, account balances not paid within 60 days are the patient's responsibility. You may pay the balance by cash, check, credit card, or pre-approved payment plan. Unpaid balances will accrue a 1½% monthly interest charge and/or a collection fee on delinquent payments beginning 60 days from date of service. Returned checks will have a $25 fee added.

Patient/Guardian Signature:____ Date: ____________________

HIPPA CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that Personal Health Information (**PHI**) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of PHI about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your PHI and information about treatment, payment, or health care operations.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose PHI for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. If you choose to give consent to this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

By signing below, you are giving consent to the use or disclosure of your Personal Health Information according to the rules and regulations of the Health Insurance Portability and Accountability Act.

Patient/Guardian Signature:____ Date:___________________