Raval Facial Aesthetics & ENT, PC
Personal Information

Date_____

First Name_____Last Name_____Middle Initial_____

Preferred Name_____Address_____

City, State, Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Gender: Male Female (circle) Status: Minor Single Married Domestic Partner (circle)

Birth Date_____Social Security #_____

Employer_____Occupation_____

Who may we thank for referring you to our office? _____

E-mail Address_____ Would you like to receive our email specials? **Y** **N** (circle)

How do you prefer to be contacted? E-mail Phone Text Message (circle)

Emergency Contact_____Phone_____

Responsible Party

Who is responsible for the account? _____

Name_____

Relationship to Patient_____Birth Date_____Driver's License #_____

Social Security #_____E-mail Address_____

Address_____

Employer_____Occupation_____

Primary Insurance Information

Name of Insured _____Relationship to Patient_____

Insured's Birth Date_____Insured's Social Security #_____

Employer_____ Occupation_____

Insurance Company_____

Claims/Insurance Company Address_____

City, State, Zip_____

Insured ID #_____ Group #_____

Consent:

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to Name of Provider. I understand that 3.00% fee will be added to any credit card payment collected by the provider's office or its collection agency. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996.

Responsible Party's Signature_____Date_____