

AESTHETIC CONSULTANTS OF IOWA

Patient Registration

Patient Information

PLEASE PRINT

NAME LAST FIRST M.I. SS# social security number

ADDRESS:

Birthdate: Age: Sex: City Marital Status: M S W D State Zip

Home Phone Work Phone: Cell Phone

Please indicate which is your best daytime contact – home phone/work phone/cell phone

e.mail address: Family Doctor:

Referred by

- Doctor Internet Former patient lookmybestnow.com Yellow Pages lookingyourbest.com Dex Other Yellow Book Friend Other Hospital

Patient Employer

Insurance Information

Employer:

PLEASE PROVIDE CARD FOR COPYING

Address:

Insurance name:

Policy Holder's Name

PolicyHolder's Birthdate

Phone:

Employer

Spouse and/or Other Person Responsible for Account

Name Last First MI SS# social security number

Employer: Work Phone # Birthdate

Other Responsible Party : Last First MI SS# social security number

Address & Phone #

IS THIS A WORK RELATED INJURY: YES NO DATE OF INJURY

IS THIS RELATED TO AN AUTO ACCIDENT: YES NO DATE OF INJURY

RELEASE AND ASSIGNMENT

I hereby authorize the Aesthetic Consultants of Iowa to release to my insurance carrier or its designated representative any information including the diagnosis and records of any treatment rendered to me during the period of such medical and/or surgical care. Photographs may be released to my insurance company as needed for payment of claims and prior approval of surgical procedures. I also authorize and request direct payment of any medical and/or surgical benefits to be made payable to said Aesthetic Consultants of Iowa for services provided by it. I authorize Dr. Grado and/or his employees to correspond with my referring physician regarding any information including the diagnosis and records of any treatment rendered to me during the period of such medical and/or surgical care.

Signature

Date

FINANCIAL POLICY

We feel it is important for you to understand the financial policy. You are ultimately responsible for payment of your account regardless of whether or not you have medical insurance. We are always willing to discuss fees with you at any time, and encourage you to ask.

1. Insurance copays are expected at the time of service for office visits and office procedures.
2. Upon receipt of payment from your insurance company, you will be billed for any remaining balance. Unless other arrangements have been made, the unpaid balance will be subject to a finance charge of 1.5% per month starting at 90 days.
3. If you are making a claim under worker's compensation and your claim is denied, you are ultimately responsible for payment of your account. You may need to verify coverage with your employer.
4. Any collection costs incurred by our office will be your responsibility.
5. By providing us with your wireless/cell phone, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.

PHOTOGRAPHY POLICY

Many procedures require photographs: I consent to be photographed and photographs will remain the property of Aesthetic Consultants of Iowa. I give permission for these to be used for insurance payment and approval if applicable. If I give permission, these may be used for educational and demonstrated purposes including publication, and I will not be identified by name.

VERIFICATION

I have read and understand the written financial policy and photography policy of this office. I agree to make financial arrangements for payment of balance in full in accordance with this policy.

Signature

Date