

**AESTHETIC CONSULTANTS OF IOWA**  
**Plastic Surgical Center**  
**Patient Information**

PLEASE PRINT

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

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

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**Please indicate best daytime contact – home – work or cell phone**  
e:mail address: \_\_\_\_\_ Family Doctor \_\_\_\_\_

**Referred By**

\_\_\_\_ Doctor \_\_\_\_\_ Internet \_\_\_\_\_  
\_\_\_\_ Former patient \_\_\_\_\_ lookmybestnow.com  
\_\_\_\_ Yellow Pages \_\_\_\_\_ lookingyourbest.com  
\_\_\_\_ Dex \_\_\_\_\_ loveyourlook.com  
\_\_\_\_ Yellow Book \_\_\_\_\_ other \_\_\_\_\_  
\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_ Hospital \_\_\_\_\_ Friend \_\_\_\_\_  
Other \_\_\_\_\_

<b>Patient Employer</b>	<b>Insurance Information</b>
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Employer: \_\_\_\_\_ **PLEASE PROVIDE CARD FOR COPYING**  
Address: \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
PolicyHolder's Birthdate \_\_\_\_\_  
Phone: \_\_\_\_\_ Employer \_\_\_\_\_

**Spouse and/or Other Person Responsible for Account**

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Last First MI social security number  
Employer: \_\_\_\_\_ Work Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

Other Responsible Party : \_\_\_\_\_ SS# \_\_\_\_\_  
Last First MI social security number  
Address & Phone # \_\_\_\_\_

IS THIS A WORK RELATED INJURY: \_\_\_ YES \_\_\_ NO DATE OF INJURY \_\_\_\_\_  
RELATED TO AN AUTO/OTHER 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

please continue to back side of form

**Privacy Consent – Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change the notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**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.

**E-Mail Policy**

By consenting to the use of e-mail with Dr. Charles Grado and Aesthetic Consultants of Iowa (ACI) (Plastic Surgical Center), you agree that ACI may forward e-mails as appropriate for diagnosis, treatment, reimbursement and other related reasons. As such, ACI staff members, other than the recipient, may have access to e-mails that you send. Such access will only be to such persons who have a right to access your e-mail to provide services to you. Otherwise, ACI will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law. ACI reserves the right to save your e-mail or information contained within your e-mail in your medical record.

ACI will use reasonable means to protect the privacy of your health information sent by e-mail. However, because of the risks associated with the use of the internet and e-mail, Dr. Charles Grado and ACI cannot guarantee that e-mail communications will be confidential. Additionally, ACI will not be liable in the event that you or anyone else inappropriately uses your e-mail. ACI will not be liable for improper disclosure of your health information that was released unintentionally.

**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, e-mail 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** \_\_\_\_\_