

**PATIENT INFORMATION SHEET**

Patient’s Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FIRST INITIAL LAST**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Gender: □ Female □ Male

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Email Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide a phone number(s) that we are authorized to leave personal health information ON:**

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: **\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-contracted Provider Financial Agreement and HIPAA practices:**

\_\_\_\_I verify this information to be correct. I authorize treatment of the person named above and agree to pay all fees for medical and cosmetic services. I understand that I will be asked for a copy of photo ID. I hereby understand I am financially responsible for services and payment is due at the time of each visit. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how you can access this information.

\_\_\_\_I am aware that Sima Medical & Cosmetic Clinic does not participate with insurance, their discounts or write offs.

\_\_\_\_I have been given an opportunity to contact my insurance prior to obtaining medical services at Sima Medical & Cosmetic Clinic to confirm my benefits, to obtain prior authorization if needed to see someone out of network and to obtain participating providers within my insurance plan.

\_\_\_\_I understand that this non-participating provider is prohibited from waiving co-payments, deductibles, coinsurance or member cost sharing.

\_\_\_\_I am voluntarily choosing on behalf of myself or child/legal guardian to obtain the services or procedures from Sima Medical & Cosmetic Clinic.

\_\_\_\_There are no refunds for services rendered, or packages purchased. Returned goods will render credit within Sima Medical & Cosmetic Clinic.

\_\_\_\_I acknowledge that I understand the Notice of Privacy Practices of Sima Medical & Cosmetic Clinic given to me upon registration. This signed form will also be retained in your medical record and will remain effective until revoked by you in writing. Patient has the right to review the health care provider’s privacy notice, to request restrictions on health care provider’s uses and disclosures of the health care information and to revoke this consent to release information.

\_\_\_ I acknowledge that there will be a $35.00 fee for missed appointments and for cancellation made less than 24 hours of appointment.

\_\_\_Your signature provides consent to leave messages on your answering machine, voicemail or at provided email address.

\_\_\_ Your signature provides consent to photography of treatments and possible use in before and after examples. Your identity will not be shown.

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Patient, Parent or Guardian Date