



## Patient Registration Form

ALLISON LIED, M.D.

LIED PLASTIC SURGERY, LLC.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSI #: \_\_\_\_\_ Marital Status:    S    M    W    D

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_

### GUARANTOR OF INSURANCE, IF OTHER THAN THE PATIENT

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

Employer Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient's Relationship to Insured:      **SELF**              **SPOUSE**              **CHILD**              **OTHER**

PHARMACY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

### EMERGENCY CONTACT

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### NOTICE OF PRIVACY PRACTICES (HIPAA)

My signature below indicates that I understand and or have received a copy of the notice of privacy practices.

\_\_\_\_\_

**PAYMENT POLICY**

All professional services rendered are charged to the patient (or the person financially responsible). Necessary forms will be completed to expedite insurance payments. The patient is responsible for all fees, regardless of insurance coverage. It is necessary to pay for services rendered at the time of service if there is no insurance policy. Patients with a copayment are required to pay at the time of service or a \$5.00 billing fee will be assessed. I agree to pay the balance due from my statement within 10 days of the statement date, unless prior arrangements have been made with the office. If payment is NOT made within a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release any information necessary to the collection agency selected by the medical provider/providers who have treated me.

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize the release of any medical or other information necessary to process my claims to my insurance carrier. I also request payment of government benefits either to myself, or to the party who accepts assignment. Furthermore, I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered services or materials.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

We do not disclose your personal identifiable data to any subsidiaries or organization other than for purposes for your continued medical care coordinated with other Physicians.

I do understand that a fee of \$45.00 will be charged for all missed appointments without prior 24 hours notice.

I do understand there is a \$50.00 fee for returned checks.

I do understand there is a \$20.00 fee for any FMLA papers to be filled out.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_