Chicago Cosmetic Surgery And Dermatology

REGISTRATION INFORMATION

p. 312.245.9965 f. 312.245.9964

Referred by: ☐Insurance ☐Our Website ☐CS Magazine ☐Today's Chicago Woman ☐Friend____________________

☐Other Doctor__________________ ☐Other ___________________ Today's Date: __________________

PATIENT INFORMATION

LAST NAME FIRST NAME MI			BIRTHDATE	SOCIAL SECURITY #	
HOME ADDRESS		CITY	STATE	ZIP	SEX ☐ MALE ☐ FEMALE
HOME #	WORK #	MOBILE #		SPOUSE'S NAME (if applicable)	
EMAIL ADDRESS					

RESPONSIBLE PARTY INFORMATION (If other than self)

NAME LAST FIRST MI				HOME #
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:		OCCUPATION
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS		
CITY	STATE	ZIP

EMERGENCY INFORMATION

NEXT-OF-KIN – Other than spouse RELATIONSHIP				HOME #
NEXT-OF-KIN ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER	Effective Date

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Chicago Cosmetic Surgery and Dermatology OR any medical benefits payable to me for the services provided at Chicago Cosmetic Surgery and Dermatology. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

x____

Patient Signature or Signature of Guardian or Parent Date

PHONE RELEASE FOR MEDICAL RECORDS

I __________________ Give permission to CCSD to leave a detailed message on my phone regarding prescription refills, test results and treatments. Please designate which number these calls are to be received ________________________________.

NOTICE OF PRIVACY PRACTICES

As indicated by my signature below, I acknowledge I have read and understand the Notice of Privacy Practices.

x____

Patient Signature or Signature of Guardian or Parent CCSD Member

CREDIT CARD AUTHORIZATION

You are responsible for all charges that you receive. If charges are not paid in full within **60 days**, we will bill your credit card listed below. This is not done as a collection tool, rather as a courtesy to our patients. We also have a strict 24 hour cancellation policy, and you will incur a charge if you do not adhere to this policy. Your signature below gives us authorization to bill your credit card for these expenses.

PRINT NAME ____

PATIENT SIGNATURE ____

DATE ____

CREDIT CARD# VISA ,MC, or AMEX ____

EXPIRATION DATE ____