AQUA MEDICAL SPA

TOLL FREE: 877-231-3376

www.AquaMedicalSpa.com

FACE SHEET/PATIENT INFORMATION

Name______________________________ Date of Birth______________ Age______ Sex _________

Mailing Address______________________________ City____________________ State____ Zip ____________

Home Phone____________________ Cell Phone ______________________ E-Mail Address:________________________

Employer ____________________________________ Employer Phone # ______________________________

Social Security # ______________________ Emergency Contact ____________________________________

Primary Physician____________________________ Referring Physician______________________________

*Primary Insurance ________________________________ ID Number ______________________________

Cardholder's Name________________________________ Cardholders SSN # __________________________

Relationship to Patient____________________________________ Cardholder's Date of Birth__________________

Cardholder's Employer____

*Secondary Insurance_______________________________ ID Number________________________________

Cardholder's Name ________________________________ Cardholder's SSN # __________________________

Relationship to Patient ____________________________________ Cardholder's Date of Birth __________________

Cardholder's Employer____

I hereby authorize my insurance benefits including Medicare to be paid directly to Aqua Medical Spa. This assignment will remain in effect until revoked by me in writing I understand that I am financially responsible for all charges whether or not paid by said insurance. I herby authorize said assigned to release all information necessary to secure that payment. In the event that this account is assigned to collections, I agree to pay all cost of collection including reasonable attorney fees. It is the policy of Aqua Medical Spa to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability.
If you believe you have been denied a benefit of some service because of your race, color, national origin, religion, sex, age or disability, you may file a complaint of discrimination with our office, either verbally or in writing.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_______________________________ **Date** ____/____/_________

PAYMENT POLICY:

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered and cosmetic services at the time of service.

COMMERCIAL PATIENTS WHO ARE NOT IN-NETWORK: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the total bill at the time of service.

COMMERCIAL PATIENTS WHO ARE IN-NETWORK: Patients who are covered by private, commercial plans in which our physicians are providers will be required to pay the balance of the bill before or on the date of your next visit if we have not been paid from your insurance company within 60 days we will provide you with the information necessary to contact your insurance company upon request.

Patient or Responsible Party Signature _______________________________ **Date** ____/____/_________

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FACE SHEET/PATIENT INFORMATION *CONTINUED*

RACE:

__ American Indian or Alaska Native　　__ Asian　　__ Native Hawaiian or Other Pacific

__ Black or African American　　__ White　　__ Hispanic

__ Other Race ________________　　__ Native Hawaiian or Other Pacific Islander　　__ Unreported/ Refused to Report

ETHNICITY:

__ Hispanic or Latino　　__ Not-Hispanic or Latino　　__ Unreported/Refused to Report

PRIMARY LANGUAGE:

__ Arabic　　__ Chinese　　__ English　　__ French

__ Korean　　__ Spanish　　__ Other ________________________________

ePRESCRIBING CONSENT:
ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information - like drug interactions and your prescription history. The benefit to you: less confusion over handwritten prescriptions or unclear phone calls, reduced possibility of medical errors, fewer trips to drop off at the pharmacy, and a safer, faster, easier way to get your prescription filled.

Patient Signature ___________________________________ **Date** ____/____/_________