PATIENT REGISTRATION FORMS

IN ORDER TO SERVE YOU BETTER, PLEASE FILL THE FOLLOWING FORMS

Wilberto Cortes MD
Facial and Body Plastic Surgeon, Hand Surgeon and Micro - Surgeon

Personal Information and Insurance Verification Form

Description and definition of Personal Information and Insurance Verification Form: *This form provides specific information about the type and extent of the insurance coverage you receive. In addition, the personal information is used for insurance verification and claim submission.*

PATIENT INFORMATION

Patient Name:

Address:

City/ State:

Zip:

Home Phone: (______) -

Cell phone number: (______) -

Social Security #:

Date of Birth:

Sex: Male Female

Nearest relative Tel #:

Email Address:

BILLING INFORMATION – PARENT/LEGAL GUARDIAN (IF DIFFERENT FROM ABOVE)

Parent/Guardian:

Address:

City/ State: Zip:

Phone: ( )

Responsible party Date of Birth:

Relationship to patient:

INSURANCE INFORMATION

Insurance Carrier:

Subscriber Group #:

Subscriber Name, if different from above:

Subscriber date of birth:

Patients relationship to Subscriber: Self Spouse Child Other:

DO YOU HAVE SECONDARY INSURANCE? Yes No

If yes, please provide a copy of the insurance card.

Is this injury the result of an accident involving another party? Yes   No

If injury at work, please provide the information below:

Employer:

Employer Address:

Employer phone number:

I hereby assign, transfer, and set over to RejuVenus Aesthetics all of my rights, title and interests to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by the insurance. I understand that if any unpaid portion of my personal balance becomes sixty (60) days delinquent and further collection efforts are necessary; I agree to pay all costs and attorney's fees incurred by Wilberto Cortes M.D. in said collection efforts.

________________   _____________

Signature of patient or legal representative   Date

____

Patient name

HIPPA Notice of Acknowledgment Form

Description and definition of the HIPPA Notice of Acknowledgment Form: Most healthcare insurance companies and providers are to adhere to the HIPAA regulation guidelines. The HIPAA law is a multi-step approach that is geared to improve the health insurance system. One approach of the HIPAA regulations is to protect privacy. This is in Title IV which defines rules for protection of patient information. All healthcare providers, health organizations, and government health plans that use, store, maintain, or transmit patient health care information are required to comply with the privacy regulations of the HIPAA law. The complete HIPAA law is concentrated in simplifying the health care system and ensuring security for patients. Title IV is a safeguard ensuring the protection of privacy for your medical information. Along with federally ensuring your privacy, the HIPAA law is intended to lead to reduced fraudulent activity and improved data systems.

I am aware of the HIPPA Privacy Practices for *RejuVenus Aesthetics* (Dr. Wilberto Cortes) and the copies of *RejuVenus Aesthetics* patient privacy policy was given to me on _______.

______________ ____________

Signature of patient or legal representative Date

____

Patient name

Consent for Photograph Form

Description and definition of the Consent for Photograph Form: *Dr. Wilberto Cortes takes photographs as part of your medical records. These photographs are strictly taken for treatment or hospital care operation. In the event that these photographs are used for other purposes (research, marketing, public edution, news, public relation or documentary an additional form to consent to photograph and authorization for use and disclosure will be provided to you.) The photographs can not be use for anything unrelated to treatment operation without you prior consent.*

The undersigned hereby consents to be photographed while receiving treatment at RejuVenus Aesthetics (Dr. Wilberto Cortes) or the hospital, with the understanding that the images from such photographs may be used for my treatment or for RejuVenus Aesthetics health care operations such as insurance claim processing, claim appeal to your insurance companies, peer review and medical education as Dr. Wilberto Cortes deem appropriate, and that such can not be use for the following purposes:

1. Marketing
2. Research
3. Internet marketing
4. Publications
5. News or documentary
6. Public relations

The term "photographs" as used herein includes video or still images in digital or any other format, and any other means of recording or reproducing images.

_______________ _____________

Signature of patient or Date

legal representative

____

Patient name

Authorization to Release Medical Information Form

Description and definition of the Authorization to Release Medical Information Form:. Patient medical information is confidential and private. It cannot be released without the patient's consent. Because insurance companies sometimes need to refer to medical information before making a determination on a claim, patients need to sign an authorization to release medical information to *RejuVenus Aesthetics* (Dr. Wilberto Cortes) in order to process your claim on your behalf.

I authorized *RejuVenus Aesthetics* (Dr. Wilberto Cortes) to disclose complete information to _________concerning his medical findings and treatment of the undersigned.

Further, I authorize him to testify without limitation, as to all medical findings and the treatment administered to the undersigned, in any legal action, suit, or proceedings to which I am, or may become party; and waive on behalf of myself and any person who may have interest in the matter provisions of law relating to the disclosure of confidential medical information.

________________ ____________

Signature of patient or legal representative Date

Signature On-file Form

Description and definition Signature On-file Form: *Signature on File Form is used to facilitate claim submission to the insurance for the services provided by Dr. Wilberto Cortes. Rather than having you sign each time a claim is submitted on your behalf, this form allows RejuVenus Aesthetics to bill your insurance company for services until you are discharge from the clinic.*

I authorize any holder of medical or other information about me to release to (the Social Security Administration and Health Care Financing Administration or its intermediaries, carriers, and agents or name of insurance company), any information needed to determine the benefits for this or related claim.

Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to *RejuVenus Aesthetics* (Dr. Wilberto Cortes). Regulations pertaining to Medicare assignment of benefits apply.

_________ _____________

Signature of patient or legal representative Date

____

Patient name

Assignment of Benefits

Description and definition of Assignment of Benefits Form: *The Assignment of Benefits and Payment Form is used as authorization to your insurance plan to send payment directly to Dr. Wilberto Cortes.*

I hereby authorize and instruct that ________Insurance Company pay authorized insurance benefits, on my behalf, by check made out and mailed to:

RejuVenus Asthetics

2105 W Davis St. Suite B

Conroe, Tx 77304

for professional services or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. This is a direct assignment of my right and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges. I also understand that any services not covered by my insurance will become solely my (the patient's) responsibility. A photocopy of this assignment shall be considered as effective and valid as the original.

________________ ____________

Signature of patient or legal representative Date

____

Patient name

Office Procedures and Medical Supplies Form

Description and definition of office Procedures and Medical Supplies Form: *Most medical insurance do not cover for medical supplies during your visit to our office. For this reason, this form state our financial disclosure when it comes to medical supplies and office procedures.*

I understand that my health insurance might not cover the supplies used during my visits to *RejuVenus Aesthetics*. For this reason, I will choose one of the following options:

☐ I will buy all the supplies needed during my office visit. *RejuVenus Aesthetics* will provided me with a prescription that describes all the necessary supplies necessary for wound or surgical site care. I understand that I need to bring these supplies for my office visits. In the event that I forget the supplies at home, a one time fee of $10.00 will be collected at the time the services are rendered.

☐ I will pay a one time fee of $60.00 dollars and this will cover the supplies for all my visits.

☐ Iwill pay $10.00 dollars per visit to cover the supplies used during each office visit.

I understand that this fee will cover the following supplies:

- Suture removal kit
- Staple removal kit

- Gauze
- Special dressings like adaptic or xeroform
- Surgical packing dressing
- Ace wraps
- Kerlix
- Conforming bandage
- Bandaids

The following are excluded from coverage:

- Supplies needed for surgical closure of wounds that resulted before or after surgery
- Cast and splint material
- Extensive or major debridement requiring surgical trays
- Sutures

We will bill your insurance on your behalf. In the event that your insurance pays for the supplies used during your visit, we will reimburse you the difference.

________________ ____________

Signature of patient or legal representative Date

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Patient name