Urban *effects* MEDSPA

Registration Form

Date: ____/____/_____ Patient Sex: Male Female Date of Birth: ____/____/_____
MM DD YYYY *(Circle One)* *MM DD YYYY*

Patient Name: _____, _____ _____
Last Name (Family Name) *First Name (Given Name)* *MI*

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone - Home: _____ Cell: _____ Work: _____

E-mail: _____

Employer Name and Address: _____

Spouse's Name: _____ Spouse's Phone: _____

Previous Family Physician *(if applicable)*: _____

Emergency Contact *(Other than Spouse)*: _____

Relationship to Patient: _____ Phone Number: _____

PATIENT INSURANCE: Does the patient have, or is the patient covered by health insurance? *(Circle One)* Yes No

1. **PRIMARY** Insurance Company Name:_____

   Address/City/State/Zip_____

   Policy Holder *(Insured's Name)*: _____ Policy Holder Date of Birth _____

   Policy Number: _____ Group Number _____

   What relationship is Policy Holder to the Patient? *(Circle One)*: Spouse Child Self Other: _____

   Is policy through Employer? If Yes, Employer's Name: _____

2. **SECONDARY** Insurance Company Name: _____

   Address/City/State/Zip_____

   Policy Holder *(Insured's Name)* _____ Policy Holder Date of Birth _____

   Policy Number _____ Group Number _____

   What relationship is Policy Holder to the Patient? *(Circle One)* Spouse Child Self Other:_____

   Is policy through Employer? If Yes, Employer's Name: _____

   Effective Date of Policy:_____ Work Phone: _____

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MESSAGES REGARDING THE PATIENT:

___ **Yes,** *Urban Effects Medspa* has my permission to leave voice-mail messages in regard to appointments, lab results and other information related to patient visits. My preferred number for messages is: _____

___ **No,** I would prefer that *Urban Effects Medspa* not leave *detailed* information on my voice-mail other than messages for me to call the doctor's office.

CONSENT TO TREAT: I authorize the *Urban Effects Medspa* healthcare providers to administer treatment as deemed necessary for care of the patient named above. I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to *Urban Effects Medspa* for any services furnished to me by the *Urban Effects Medspa.* Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

My signature indicates that all information provided above is true and accurate:

_____ _____
Signature of Patient or Legal Representative *Date*

If patient is under the age of 18:

Full Name of Parent or Legal Representative: _____

Address if different than your own: _____

City _____State _____ Zip _____ Day Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
Urban Effects Medspa

My signature below indicates that I have been given an opportunity to read this practice's NOTICE OF PRIVACY PRACTICES and to have any questions answered before signing.

Signed: _____Date: _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:
[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient
[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY: Employee Signature: _____Date_____

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____