PATIENT REGISTRATION FORM

PATIENT INFORMATION: E-MAIL ______________________________

LAST NAME____________________________ FIRST_____________________________ MI_______ SEX: M F

ADDRESS:________________________________ CITY: ________________________STATE ___ ZIP:_________

DATE OF BIRTH:________________ MARITAL STATUS: M S D SEP SSN:______________________________

HOME PH:___________________ CELL PH.:_________________ WORK PH:_____________________________

EMPLOYER:________________________ EMPLOYER ADDRESS:_____________________________________

SPOUSE'S NAME:______________________ARE YOU BEING SEEN FOR A WORK RELATED INJURY? Y/N

DATE OF MOTOR VEHICLE ACCIDENT:__________________DATE OR ONSET OF INJURY________________

IF PATIENT IS 18 OR UNDER:
FATHER'S FULL NAME____________________________ HOME PH.______________WORK PH.____________

MOTHER'S FULL NAME___________________________ HOME PH._______________ WORK. PH.__________

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?
If patient is the responsible party, do not complete this section-**CHECK HERE** ☐

LAST NAME ___________________________ FIRST_____________________________ MIDDLE_______________

ADDRESS:____

CITY/STATE:________________________________ ZIP:_______________ HOME PH.:______________________

EMPLOYER:____ WORK PH.:______________________

SSN:___________________________________

INSURANCE INFORMATION: (In addition to listing all insurance plans, please present your insurance cards so that we may obtain a copy.)

PRIMARY INSURANCE:____

CLAIMS MAILING ADDRESS____

CITY/STATE:____ ZIP____________ PHONE: (   )___________

INSURED'S NAME: ______________________________________ DATE OF BIRTH_____________

RELATIONSHIP TO PATIENT:_________________ SEX: M F

INSURED'S ADDRESS:_____________________________________ SCHOOL:_______________FULL/PART TIME

EMPLOYER:________________________________ GROUP NO.___________________ID#___________________

SECONDARY INSURANCE:____

CLAIMS MAILING ADDRESS____

CITY/STATE:____ ZIP____________ PHONE: (   )___________

INSURED'S NAME: ______________________________________ DATE OF BIRTH_____________

RELATIONSHIP TO PATIENT:_________________ SEX: M F

INSURED'S ADDRESS:_____________________________________ SCHOOL:_______________FULL/PART TIME

EMPLOYER:________________________________ GROUP NO.___________________ID#___________________

NEAREST RELATIVE OR FRIEND, NOT LIVING WITH YOU, THAT WE MAY CONTACT IF WE ARE UNABLETO REACH YOU OR IN CASE OF AN EMERGENCY.

NAME:____ PHONE:_______________________________

WHOM MAY WE THANK FOR REFERRING YOU TO DR. MELISSA HOLLIE?
REFERRED BY DOCTOR__________________________ REFERRED BY FRIEND//PATIENT______________
YELLOW PAGES__, TV.__ NEWSPAPER/MAGAZINES__, RADIO, ____ INTERNET____, OTHER_________.

CONSENT TO TREATMENT:I HEREBY CONSENT TO MEDICAL TREATMENT RENDERED OR PRESCRIBED BY DR. MELISSA HOLLIE.

DATE:____SIGNATURE_______________________________

(If Minor, Parent of Legal Guardian Must Sign)

Aesthetic Medical Associates
of the Central West End
3920 Lindell Blvd., Ste. 105 St. Louis, MO 63108
314-652-8923 office | 314-652-8925 fax

CONSENTS/AUTHORIZATIONS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY BENEFITS

I hereby authorize the release of any medical information necessary to bill my insurer, and authorize payment or medical/surgical benefits to be made to Aesthetic Medical Associates, L.L.C.

DATE:_______________________ SIGNATURE:_____________________________________

CONSENT FOR PHOTOGRAPHY

Pre-treatment and post-treatment photographs are recommended to follow your medical care. Pre-treatment and post-treatment photos may be viewed for educational purposes by our physician or patients; or on request, sent to your insurance company. Educational purposes may include: use in physician consults with individual patients or use in physician seminars presented to potential patients or for medical associations.

This consent will be in effect until physician discontinues use of these photographs.

It is our intention to handle all photographs with the highest regard for confidentiality.

DATE:_______________________ SIGNATURE:_____________________________________

RECEIPT OF PRIVACY NOTICE ACKNOWLEDGEMENT

By my signature below, I acknowledge I received the current Privacy Notice of Aesthetic Medical Associates, L.L.C.

DATE:_______________________ SIGNATURE:_____________________________________

Aesthetic Medical Associates
of the Central West End
3920 Lindell Blvd., Ste. 105 St. Louis, MO 63108
314-652-8923 office | 314-652-8925 fax

PAYMENT POLICIES

We accept cash, check, Visa, MasterCard, American Express, Discover, and most insurance programs.

If you have insurance, the following apply:

1. It is YOUR responsibility to give us the correct information about your insurance company, and to follow the rules of your insurance company. You must comply with such rules as a valid referral form and pre-certification of testing and surgery, in order for your claims to be paid. We will assist you, but if claims are denied because of your failure for the above, you will be responsible for paying the denied services.
2. You are responsible for paying any deductibles, co-payments or non-covered services.
   a. Work Related Injuries:
      A. If your employer has approved treatment: you will not be charged or billed.
      B. If your employer does not approve treatment and YOU select us for your treatment, you will be billed and charged for the services.
3. If you are involved in a lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
4. We file group insurance claims and by law, must file Medicare claims.
5. Children that are brought to our office under 18 years of age must have Authorization from their parent or legal guardian before being treated by our providers.
6. Certegy check services are used at the time of service for any check written. The transaction will be converted to electronic payment. The check will be returned to the patient along with a receipt. A service fee of $30.00 will be charged to the patient per returned check.
7. A 24-hour notice is requested on cancellations. If a patient does not show up for an appointment it will be considered a no show. No show appointments are documented in the patient's chart. If they become excessive the patient will be billed a fee and/or requested to seek care through another physician.

   In the event of non-payment for charges you have been made responsible, you will become responsible for any legal and/or collection fees.

   I have read all the above terms and assume full responsibility for paying any medical services charges and finance charges according to these terms.

DATE:_____________________________________

SIGNED:__________________________________

Aesthetic Medical Associates of the Central West End

3920 Lindell Blvd., Ste. 105 St. Louis, MO 63108
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Name Birthdate

Chronic Illness Onset Date

Medications Start Date/Finish Date

Allergies/Drug Allergies Side Effects

Family History (Parents,Siblings,Children)

Hospital/Surgery Year

Nutritional Supplements

Tobacco Use Y/N Substance Use Y/N Alcohol Use Y/N

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The physician and staff of this practice will comply with the new national privacy standards to protect the rights of privacy of our patients and in the handling of our patients' health information. In the course of providing care to you, we create a record of the care and services you have received from us. We understand that medical information about you is personal. We are committed to protecting that information. This notice applies to your medical record and the way we handle the information therein.

How Your information Will Be Used

For treatment: We may disclose your information in managing your health care treatment by sharing your personal health information with other physicians, hospitals, and therapists. As our patient, you will be contacted regarding appointments, test results, and treatment options. During the course of treatment, some of your information may be shared with product manufactures as part of research and studies being conducted for product safety or efficiency.

For payment: Some aspects of your personal health information such as name, address, and social security number will be used for billing purposes. This information will be shared with our billing entity, health insurance carriers and may be shared with our collection agencies and/or attorneys. During this process we may contact you by mail or phone with regard to insurance benefits, account payment and possible collection activities.

For Operations: In the course of both treatment and billing, your personal heath will be used within our organization. It may be used in the review of quality care initiatives, insurance audits, liability management, accounting processes, and other operational functions. With your cooperation, we may disclose your information to family or others involved in your care or payment activities.

For Marketing: We may ask to use your photos (unnamed) In the course of business activities promoting our services, such as seminars. We may use your information in the context of patient care surveys, service and product announcements, and cooperative community service fund raising. This may be accomplished by phone or mail.

As Permitted or Required by Law: We may disclose your information to regulatory agencies, such as during licensure and certifications, audits, or other proceedings; for administrative or judicial proceedings; to public health officials and child/family service agencies; or to law enforcement authorities, such as to comply with a court order or subpoena.

The Rights of privacy of our patients are as follows.

The right to access personal health information. You may request to view your records and obtain a copy. We have a procedure for handling your request in a timely manner, which is required to be within 30 days, and there may be a fee to cover the cost of copying and mailing the record to you.

The right to request restrictions on certain uses and disclosures of your health information. We will comply with your request as best we can but we are not required to agree with the requested restriction.

The right to confidential communications during the use and disclosure of your health information.

The right to request amendments to the information in your medical record. We have a procedure for handling your request. We may deny your request if you do not follow our procedure, if your request does not include a reason to support it or under a few other specific conditions.

Complaints
If you believe your privacy rights have been violated, you have the right to file a complaint with us or the federal government. You will not be penalized for filing a complaint. You may request a Complaint Form from our staff to submit in writing.

Changes to this Notice
We reserve the right to change the terms of this notice at any time to comply with changes in the Health Information Portability Accountability Act (HIPPA). We will provide you a copy of the revised notice at our next contact with you after the revision date.

Finally, we will not disclose your personal health information for any other purpose than that described above without your permission. You may revoke an authorization to use or disclose your personal information, except to the extent that action has already been taken. Such a request must be made in writing.

If you have any questions about this notice, you may contact our Privacy Officer.

Aesthetic Medical Assoc.
3920 Lindell Blvd.
Suite 105
St Louis, MO 63108
Ph. 314.652.8923

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PATIENT POLICY EFFECTIVE April 20th, 2018

Providing great patient care to achieve great patient wellness is our ultimate goal. We will do our best to provide you with excellent service. To better serve you and provide continuity of care, please find our office hours and the patient policy of this practice below:

Scheduled office hours:

Monday: 8am-4pm, (LUNCH noon-1pm)
Tuesday: 8am-4pm, (LUNCH noon-1pm)
Wednesday: 8am-4pm, (LUNCH noon-1pm)
Thursday: 8am-4pm, (LUNCH noon-1pm)
Friday: 745am-Noon

1. **NO** requests for current prescription refills will be taken by staff or Dr. Hollie outside normal business hours. **DO NOT leave a prescription request on the exchange number of 314-560-3575, that line is reserved for EMERGENCIES ONLY AND FOR ADMITTING PATIENTS TO THE HOSPITAL.** Please call the pharmacy for refill requests.

2. **If you are experiencing an emergency or life-threatening illness, call 911 or proceed to the nearest ER. The admitting hospital will contact Dr. Hollie immediately.**

3. **Inappropriate use of the exchange number** will result in a $37.50 fee charge billed directly to the patient. Continued abuse of the exchange will result in dismissal from the practice. Dismissal will be determined by Dr. Hollie and staff after evaluation of the number of calls above reason or if it is deemed that calls were not an emergency in nature and could have been handled during office hours.

4. **Copay/payment** for service is expected at the time of the office visit.

5. **Narcotics and controlled substances** will only be prescribed if clinically necessary and only for acute issues. **This office does not fill narcotics or controlled substances for**

chronic or ongoing medical needs. These cases will be immediately referred to the Pain Management Clinic for further evaluation and treatment.

6. **No Show and Same Day Cancellation Fee** - There will be a $25 No Show Fee for any appointments missed or neglected to be rescheduled within 24 hours of the scheduled appointment. There will be a $25 Same Day Cancellation Fee for any appointments that are cancelled on the same date of the scheduled appointment. 2 or more No Show Fees/Same Day Cancellation Fees assessed will be grounds for termination of patient.

7. **Family Medical Leave/Disability/Return to Work paperwork –** There is a per page charge for paperwork/documentation requested.

8. **Failure to follow office protocol** will result in immediate termination of patient. **Disruptive behavior towards staff** via phone or in office will result in immediate termination of patient.

9. In order to provide the best medical care for the patient and in the interest of respecting the valuable time for the patient and Dr. Hollie, the following office protocol has been established:

    All messages/calls will be directed to the registrar or medical assistant for review by Dr. Hollie. Return calls will be made by Dr. Hollie's medical assistant at a designated time each day. Return calls will not be made by Dr. Hollie during normal business hours as this is disruptive to in office patient care.