ASPEN
FACIAL PLASTIC SURGERY

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PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

DEMOGRAPHICS

Patient Name _____
Last Name First Name M.I Maiden

Parent / Guardian _____
Last Name First Name

Mailing Address _____
Street City State Zip

Cell Phone (_____) _____

Home Phone (_____) _____

Email _____

Employer _____

Gender - ☐ Male ☐ Female

Marital Status _____

Date of Birth _____ / _____ / _____

SSN# _____

Preferred Language (if not English) _____

Preferred Pharmacy _____
Name / City

How did you hear about us (referral (name), physician (name), internet, Instagram, Facebook, other)?_____

EMERGENCY CONTACT (Not living with you)

Name _____Relationship _____ Phone (_____) _____

FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at time of service.** I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. A $25 charge will be applied to all returned checks. **I understand that some medical services performed in the office (cosmetic procedures, injections, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

_____
Patient or Patient's Representative Signature Date

If signed by Representative, state name of: Representative _____ Relationship to Patient _____