



Demographics (please print)

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____

DOB _____ Gender M/F _____ Marital Status _____

S/S # _____

e-Mail Address _____

Responsible Party _____

Patient's Occupation _____ Employer _____

Pharmacy Name _____ Phone Number _____

Reason for today's visit _____

How did you hear about us?

- The Villager Living Magazine Woodlands Community Magazine
 Friend: _____
 Doctor: _____
 Event: _____
 Other: _____

Signature _____

Date _____



PATIENT FINANCIAL AGREEMENT

Thank you for allowing our office the privilege of serving your medical needs. The Woodlands Wellness & Cosmetic Center is a place where the genuine care and welfare of our patients is our highest mission. That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.
For your convenience, we accept cash, checks, Master Card, Visa, Discover and American Express.
2. Returned checks are subject to a \$25 fee. Balances older than 30 days will be subject to collection fees and/or interest charges unless other arrangements have been made. As a member of the Credit Bureau, unpaid balances are reported at our discretion.
3. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Therefore you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
4. If any Pre-certifications are required by your insurance company for allergy testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office can not be held responsible.
5. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing the Woodlands Wellness & Cosmetic Center to send your complete medical records to your insurance company once they are requested.

Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A Photocopy Of This Document Shall Be Considered As Effective And Valid As The Original.

Signature of Patient

Signature of Witness

Printed Name of Patient

Printed Name of Witness

Date

Date



**NOTICE TO ALL MEDICARE, MEDICAID,
CHAMPUS, WPS &/ OR TRICARE BENEFICIARIES**

The Woodlands Wellness & Cosmetic Center does not participate in Medicare, Medicaid, Champus, WPS or TriCare programs and has chosen to opt out of Medicare. The Woodlands Wellness & Cosmetic Center has found that due to the pittance allowed by these government agencies, we are unable to meet overhead expenses. The Woodlands Wellness & Cosmetic Center is a Free Enterprise and would like to be able to extend quality medical care to you; however, due to the rules instituted by the government of the United States pertaining to these government agencies, the practice is unable to administer medical care to patients covered by them unless you read and sign the attached Waiver. We urge you to write your congressman if you have a problem with the rules instituted by these agencies.

WAIVER

I understand that The Woodlands Wellness & Cosmetic Center is not a Medicare, Medicaid, Champus, WPS or TriCare provider and has chosen to opt out of Medicare.

I accept full financial responsibility for any charges incurred.

Further, I understand that by signing this form, I waive my right to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services. Additionally, I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file to any other insurance policies.

I do not have Medicare, Medicaid

Signature of Patient

Signature of Witness

Printed Name of Patient

Printed Name of Witness

Date

Date



HIPAA - Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers of individuals who are authorized to receive my medical information:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

- Y N It is ok to send me an e-mail
- Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

- 1. _____ It is OK to leave a message re items such as lab results, vitamins, refills etc.
- 2. _____ Please do not leave specific message but a general message is OK
- 3. _____ Do Not leave any messages at all.

Signature of Patient

_____ or _____
Signature of Personal Representative

Printed Name of Patient
Representative

Printed Name of Personal

Date

Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guideline. A copy of these guidelines is available upon request.



No Show/ Cancellation Policy

No Show: If I do not show for my scheduled appointments, I will be billed at full price for the service.

Cancellation Policy: If I cancel **4 hours or less** before my appointment, then I will be charged half of the service price.

I agree to the above statements, and acknowledge the fact that my credit card will be charged if I no-show or cancel within 4 hours of the appointment.

Signature of Patient

Signature of Witness

Printed Name of Patient

Printed Name of Witness

Date

Date



CONFIRMATION OF OFFICE POLICIES

By signing this form, you are stating that you are aware of the following office policies at Woodlands Wellness & Cosmetic Center and will comply.

MY SOCIAL SECURITY NUMBER IS REQUIRED.

Labs require the use of social security numbers to ensure that they are giving results back to the correct patient. The social security number is also required on documents from the labs for insurance reimbursement. We require a social security number for all medical patients.

FOLLOW UP VISITS ARE NECESSARY FOR ADDITIONAL PRESCRIPTION REFILLS.

Dr. Davis requires that once the refills run out that you come back into the office to follow up and have lab work done. It is imperative that she sees you to ensure that you are on the correct therapy and are not developing adverse reactions. This could be three, six or nine months following your initial visit depending on the medications. Dr. Davis will not provide additional refills if you have not come in for a follow up visit.

Signature of Patient

Signature of Witness

Printed Name of Patient

Printed Name of Witness

Date

Date