Patient Information:

Patient's Name:_____
Last First Middle

Address:_____
Street & Apt # City State Zip

Home Phone:_____ **Cell Phone:**_____ **Other Phone:**_____

Drivers License #:_____ **E-mail Address:**_____

SS#: _____ **Age:**____ **Birth date:** _____ **Sex**: ☐ Male ☐ Female

Marital Status: _____ **Patient's Employer:**_____

Occupation:_____ **Work Phone:**_____ **Ext**:_____ **Is it okay to call you at work?** Yes

Address:_____
Street & Suite # City State Zip

Primary Health Insurance: *(cosmetic surgery is NOT covered by insurance)*

Insurance Company Name: _____ ☐ HMO ☐ PPO ☐ POS Active Date:_____

Policy Number:_____ **Group Number:** _____

Primary Insured Name: _____ **DOB:** _____ **SS# :**_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent

Primary Care Physician: _____ **Phone Number:** _____

I understand that office visit charges are payable on the day service is rendered. I authorize Avante Plastic Surgery to bill my insurance company for non-cosmetic care. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Avante Plastic Surgery and myself.

Any fees paid to Avante Plastic Surgery, including surgery deposits and consultation fees are non-refundable.

I hereby acknowledge that Avante Plastic Surgery is part of an organized healthcare arrangement that may share my health information for treatment, billing, and healthcare operations. I understand that a copy of the organization's notice of privacy practices, that describes how my health information is used and shared, will be provided to me upon my request. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office.

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Avante Plastic Surgery to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Patients seeking Dr. Ahmadi's surgical expertise in correcting the results from other surgeons hereby agree that they will not request Dr. Ahmadi to give any testimony beyond providing a copy of medical records. Providing expert medical testimony against another surgeon during lengthy court proceedings prevents Dr. Ahmadi from caring for his patients.

I agree to refrain from directly or indirectly publishing or airing commentary upon physician and his practice and will use all reasonable efforts to prevent any member of their family or acquaintance from engaging in any such activity. I understand that I am not permitted to directly or indirectly record, videotape or photograph at any time.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non-credit card challenge agreement is irrevocable.

Signature: _____ Date: _____