

RENATO SALTZ, M.D., F.A.C.S.
Diplomat American Board of Plastic & Reconstructive Surgery

PATIENT INFORMATION

Today's Date _____ 20____

Patient Name _____		Social Security Number _____	
_____/_____/_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
Date of Birth	Age		
Street Address _____			Apartment # _____
City _____	State _____	Zip _____	
(_____) _____	(_____) _____	(_____) _____	
Home Phone	Work Phone	Mobile/Cell Phone	
Email Address _____			

PRIMARY INSURANCE INFORMATION (If Applicable)

Insurance Company _____		(_____) _____	
		Phone	
Address _____	City _____	State _____	Zip _____
Policy Number _____	Group Number _____	Subscriber SSN# _____	
Subscriber Name _____	Subscriber Date of Birth _____	Subscriber's Relationship to Patient _____	

Reason for today's visit _____

How did you hear about us? _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Saltz to release information related to the course of my examination or treatment to other health care providers, hospitals, insurance, or institutions to further my medical care. This may include photographs.

PATIENT PHOTOGRAPHIC AUTHORIZATION

I consent to have photographs taken by Dr. Saltz or his designee. These photographs may be of me or parts of my body and may be taken in connection with any plastic or reconstructive procedure to be performed.

MISSED OR CANCELLED APPOINTMENTS

We realize that unforeseen situations arise that may necessitate changing an appointment. If you need to cancel an appointment we kindly ask that you give our office at least 24 hours notice so we may accommodate other patients who are waiting for an appointment. Appointments that are missed or cancelled without 48 hour notification will result in a \$50.00 charge. You will be billed directly for this charge. It will not be billed to your insurance company.

CHARGES AND FEES

The undersigned specifically agrees to pay all reasonable attorney's fees and court cost in the event legal action is taken to collect on your account. The undersigned further agrees to pay an additional amount representing up to forty (40%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing. A finance charge of one and one-half percent (1.5%) of the unpaid balance will be added monthly. In the event of a check being returned for any reason a fee of \$25.00 will be assessed.

Signature of Patient or Guardian

_____/_____/_____
Date