

ELLE MEDICAL
NATURAL AND HOLISTIC MEDICINE

Welcome to the office of Robert C. Levine, M.D.

PATIENT INFORMATION RECORD

TODAY'S DATE: _____

Patient's Name: _____
Last First MI

Address: _____
Street

City State Zip Code

Home Phone () _____ Work () _____ Cellular () _____
(Please circle best number to reach you during the day)

Marital Status S M D W _____ Sex: M F

Date of Birth: ___/___/___ Age: _____ Social Security #: ___/___/___

Spouse's Name _____ Date of Birth ___/___/___
Spouse's Social Security Number ___/___/___

Employer: _____

Occupation: _____

How did you learn about Elle Medical Spa? Doctor / Former Patient / Friend / Internet / Yellow Pages / Other?

Who may we thank for the referral? Name: _____

Emergency Information: Person to Call: _____ Relationship: _____

Phone: () _____ PRIMARY INSURANCE COMPANY _____

CONTRACT NUMBER _____ Your Co-Pay _____

Your Deductible _____ SECONDARY INSURANCE _____

Your Secondary Insurance's Co-Pay _____ Deductible _____

PLEASE CHECK A PAYMENT METHOD (REQUIRED):

MasterCard / Visa Debit Card American Express Prior Arrangement

Credit Card Number: _____ Exp. Date: _____ or IMPRINT MADE
Security Code: _____ (Shown on reverse side of card in the signature label)

Credit Card Authorization Signature: _____

This is a direct assignment of my right and benefits under the insurance company listed. This payment will not exceed my indebtedness to the abovementioned assignee and I have agreed to pay, in a current manner any balance of the said professional service charges over and above the insurance payment. I hereby authorize Elle Medical to charge my credit card or debit card for my co-pay, deductible or charges that are non-covered benefits. Payment is required at the time of service.

Signature of Patient or Legal Guardian: _____

ELLE MEDICAL SPA
1157 SOUTH ADAMS ROAD
BIRMINGHAM, MICHIGAN 48009
(248) 646-8600



**PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO WE
MAY HELP YOU WITH YOUR INSURANCE REIMBURSEMENT**

Consent for Health Care:

I hereby voluntarily consent to medical care and spa treatments rendered to me including but not limited to diagnostic, therapeutic treatments which may be ordered by my physician, his assistants or designee that is requested by me or deemed medically necessary or advisable. Please check and sign by your chosen option below:

This agreement and assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

OPTION 1

I, the undersigned, hereby authorize Elle Medical/ Dr. Robert Levine to release any information pertinent to my case to any insurance company, adjuster, physician, billing service employee or agent of Elle Medical Spa and/or Robert C. Levine, MD for the purpose of utilization review, quality assurance and/or billing.

Signature of Patient or Legal Guardian: _____ Date _____

OPTION 2

I HEREBY WAIVE MY RIGHTS TO OBTAIN REIMBURSEMENT FROM MY INSURANCE COMPANY

*I, the undersigned wish to waive my rights under my insurance plan(if any) and **do not** authorize Elle Medical/ Dr. Robert Levine to release any private protected health information regarding my case to any insurance company, adjuster, physician, billing service employee or agent. Under these circumstances, all charges are my responsibility. I agree not to submit bills for reimbursement from any third party payer. **My information is to remain strictly confidential. Any release of information must be approved by me in writing and will not be released unless required by law.***

Signature of Patient or Legal Guardian: _____ Date _____