HALLMARK PLASTIC SURGERY
Patient Registration

Patient Name____**Birthdate**______________
Last First Initial
Patient Address____
City__________________________**State**____________________________**Zip**__________
S. S. #_____________________Phone_______________Referring Doctor_______________

Employer____
Address____
Telephone #____

Work Injury Date______________________
Auto Injury Date_______________________
Legal Representative____
Address & Telephone #____

Spouse_________________________________
Employer_______________________________________
Address & Telephone #____

Person Responsible For This Bill____
Relationship____
Address If Other____
Primary Physician____

I certify this information is true and correct to the best of my knowledge. I will notify you of any change in the above information during the time I have a balance due on my account. I understand and agree that regardless of my insurance benefits (if any); I am financially responsible for the fees for services rendered. In the event that my insurance company should refuse payment of this account for any reason, or should make partial payment on this account, I hereby agree to pay the full balance for services rendered within 6 months. I agree to pay all costs of collection, including collection fees of the outstanding balance, in the event my account is submitted to a collection agency for collection. I understand agree to pay a finance charge at a monthly rate of 1-1/2%, annual percentage rate of 18%---which will be applied to the balance of my account 90 days from the date of service. Returned checks will be subject to an additional charge of $40.00. We accept **Visa and Mastercard.**
We shall maintain your records for a minimum of 6 years following the last encounter. Records for minor children shall be maintained until the child reaches the age of 18.

____________________________________ ______________________
Signature of Patient or Authorized Person Date