

Vitality Anti-Aging Center & Medical Spa –Registration Form

Account Number

PATIENT INFORMATION

| | | |
|--------------------------|--------------------------------------|---|
| Last Name | First Name | Middle Initial |
| Street Address | City/State | Zip Code |
| Home Telephone | Emergency Telephone | Emergency Contact |
| Social Security Number | Date of Birth (mm.dd.yy) | Sex; Male / Female |
| Preferred Provider (PCP) | Preferred Pharmacy Name/Phone Number | School Name/Phone Number Of applicable) |
| Employer | Employer Address/Phone Number | |

RESPONSIBLE PARTY/BILLING INFORMATION

| | | |
|--|------------------|----------------|
| Last Name | First Name | Middle Initial |
| Street Address (if different from above) | City/State | Zip Code |
| Home Telephone | Employer Phone | |
| Employer | Employer Address | |
| Social Security Number | | |

PRIMARY INSURANCE INFORMATION

| | | |
|--------------------|------------------------|------------------------|
| Name of Company | Office Co-Pay \$ | Insurance Telephone |
| Group Number | Policy Number | |
| insurance Address | City/State | Zip Code |
| Insured's Name | Date of Birth | Relationship |
| Insured's Employer | Address/State/Zip Code | Social Security Number |
| | | Telephone |

SECONDARY INSURANCE INFORMATION

| | |
|--------------------|------------------------|
| Name of Company | Insurance Telephone |
| Group Number | Policy Number |
| Insurance Address | City/State |
| Insured's Name | Date of Birth |
| Insured's Employer | Address/State/Zip Code |
| | Relationship |
| | Social Security Number |
| | Telephone |

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Vitality or any of its affiliates or agents, lenders, or any third party servicer acting for Vitality or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to VAC and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I authorize VAC to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Signature

Date

How did you hear about our Medical Center? • Yellow Pages • Referral Service • Physician • Emergency Room • Welcome Packet • Family/Friend • Hotel • "Employee • Health Fair/Trade Show • Direct Mail • Managed Care Plan/Insurance Company • Newspaper • Web site • Other _____ • Your e-mail address _____