Hamilton Facial Plastic Surgery, Inc.

Patient Registration Form					
Last Name:	**First Name:**	**Middle Initial**		**Date of Birth** / /	**Age:**
Address (No PO Box please)		**City**	**State**	**Zip**	
Home Phone:	**Work Phone:**	**Cell Phone:**	**Email:**		
Preferred Pronouns:	**Pharmacy:**		**Gender:** ☐ M ☐ F		

Emergency Information			
Emergency Contact:	**Relationship:**	**Home#:**	**Cell#:**

I authorize the release of my medical information to my referring or treating physician. I understand that I am requesting treatment by a non-contracted out-of-network provider(s) and facility. As such, Dr. Jason S. Hamilton, MD and Hamilton Facial Plastic Surgery, Inc. are not contractually obligated to participate with your insurance company. I, the undersigned, understand that I am financially responsible for those medical and/or surgical charges incurred by me, or my dependent. All fees necessary to collect this amount are payable by me and are disclosed to me prior to any services rendered.

Signature of Patient/Legal Guardian: _____ **Date:** _____

Hamilton Facial Plastic Surgery, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient/Guardian Signature: _____ **Date:** _____

If you wish to place restrictions on disclosure of your health information, please detail the request on the line below:

_____

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits. As a non-contracted provider, insurance plans may provide reduced benefits or none at all. In addition, Hamilton Facial Plastic Surgery, Inc will bill the patient directly without consulting the insurance company. In select circumstances, Hamilton Facial Plastic Surgery, Inc may bill the insurance company on behalf of the patient as a courtesy. Hamilton Facial Plastic Surgery, Inc. does not subscribe to "allowed amounts" as determined by your insurance company. Self-pay patients and patients receiving services deemed "not covered" by their insurance plan will be solely responsible for the full amount of their office visit and/or any procedures rendered.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature: _____ **Date:** _____

Administrative Policy and Associated Fees

All administrative or associated fees are explained below and are due at the time of services rendered.

Business Days and Hours: Our business days and hours are Monday through Friday, from 9:00 AM to 4:30 PM, Pacific Standard Time (PST). Please note we are closed on weekends and observe all major holidays.
Appointment Fees: All fees for appointments must be paid in full prior to scheduling your appointment.
Non-Refundable Policy: To honor the time of all our patients, appointment fees are non-refundable if cancellation or rescheduling occurs within two business days of your scheduled appointment. To cancel or reschedule an appointment, please contact our office during business hours.
New Patient Consultations: Fees paid for new patient consultations will be credited towards the cost of any surgical procedure booked within **six months** from the initial consultation date.

Surgery Deposit Policy - $1,500.00
A **non-refundable deposit** of $1,500 is required to secure your surgery date. This deposit will be applied directly to your total surgery costs. If you need to **reschedule your surgery**, we will honor your initial deposit and apply it to the new surgery date, provided the rescheduled surgery occurs **within six months** of the original deposit date. Please note that rescheduling beyond this six-month period will necessitate a new deposit. If you find it necessary to **cancel your surgery**, we ask that you notify our office a **minimum of 30 days** in advance of your planned surgery date. Failure to do so will result in the **loss of your deposit**.

Requests for Medical Records - $25.00
Request for copies of your medical records created by Hamilton Facial Plastic Surgery, Inc. includes a $25.00 fee.
Please note: we do not store or include videos of procedures as part of the medical record.

I have read and understand Hamilton Facial Plastic Surgery, Inc.'s Administrative Policy and Fees.
I further understand that these fees are my responsibility, and I agree to pay such fees, if applicable.

Patient/Guardian Signature: _____ **Date:** _____

Hamilton Facial Plastic Surgery, Inc.

Informed Consent

If deemed medically necessary by my provider, I authorize Dr. Jason S. Hamilton, MD to perform a nasal endoscopy (nasal exam with endoscopic camera) during my office visit. I understand that I will have the opportunity to ask questions prior to the procedure. Dr. Hamilton will thoroughly explain the risks and benefits. I understand that I can revoke my consent at any time.

Patient/Guardian Signature: _____ **Date:** _____