The Cosmetic Vein & Laser Center

●Cosmetic Laser Surgery ● Cosmetic and Medical Dermatology ● Spider and Varicose Vein Treatment ●Body Sculpting

Office: (716) 632-5200 ● Fax: (716) 632-5201 ● Website: www.cvlc.com
52 S. Union Road, Suite 203, Williamsville, NY 14221

PATIENT REGISTRATION FORM

Date: _____

Patient's Name: Last: _____ First: _____ MI: _____

Preferred First Name: _____ Date of Birth: _____

Address: _____ City _____ State _____

Zip Code_____ SS#: _____ -_____ - _____ Current Age: _____

Gender: M / F Marital Status: M / S / D / W E-Mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: Home Phone _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Date of Birth: _____

Spouse Employer: _____

Primary Physician: _____ Address: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

Referring Physician: _____ Address: _____

How did you learn about our practice? _____

Please tell us the reason for your visit here today: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Member ID#/Policy No.: _____ Group #: _____

Policy Holder's Full Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ SS#: _____ - _____ - _____

Secondary Insurance Company: _____

Member ID#/Policy No.: _____ Group #: _____

Policy Holder's Full Name: _____Relationship to Patient: _____

Policy Holder's Date of Birth: _____ SS#: _____ - _____ - _____

PLEASE COMPLETE PAGE 2 OF THIS FORM

FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office. The Cosmetic Vein & Laser Center has contracts with most insurance companies. We will bill your insurance carrier; it is your responsibility to know if your proposed treatment is covered by your insurance carrier. You will be responsible for all copays, co-insurance and deductibles. For high deductible plans, you may be asked to pay at office visit for deductible cost.

Managed Care Insurance Contracts: Patients enrolled in managed care health care plans are required to pay their copay at the time of service. After insurance has paid for services, co-insurance and deductible amounts are due upon receipt of your bill and payment can be made via a phone call to our Billing Department. If copay is not paid at time of visit, you may be billed an extra $15.00 for administrative fees.

Acceptable Methods of Payment: ● Cash ● Check ● Money Order ● Visa ● MasterCard ● American Express ● Discover Card ● CareCredit

Private Pay: Payment for cosmetic services rendered in our office is due at the time of service. We offer treatment plans which include a 20% discount for most cosmetic procedures. You may pay per treatment if you choose. There will not be a discount applied should you pay per treatment.

Billing: Any insurance balance over $250.00 will be eligible for a 10% discount if paid in full within 30 days of receipt of first billing statement. A $5.00 service charge will be added to your second and subsequent statements if not paid in full within 30 days. Any personal balance over 30 days old without current payments applied against it is considered an overdue balance resulting in delinquent status of the account. To avoid assignment to a professional collection agency, which will include an additional 33.33% surcharge, all payments due should be made promptly. If genuine financial difficulties exist, please call our Billing Department. We are happy to arrange a personalized monthly budget payment plan.

Returned Check Policy: If we receive a Non-Sufficient funds (NSF) returned check, we will immediately notify the patient or responsible party. We will request that exchange with cash for the NSF check is made in our office within 24 hours. If cash payment is not received in 24 hours, a $50.00 returned check fee will be charged along with the check amount. If payment is not received within 30 days, appropriate legal action will be taken. All future appointments will be cancelled until full amount is paid.

Cancellation/No-Show Policy: I understand that The Cosmetic Vein & Laser Center requires the following notice of cancellation for appointments:

Duration of Appointment	*Notice Required*	*Cancellation/No-Show Fee*
30 minute appointment or less	24 hour notice	$50
40-60 minute appointment	1 week notice	$100 - $200
Greater than 60 minute appointment	2-3 week notice	$200 - $500

I further understand that should I no-show or cancel without required 24-hour notice for three or more appointments, I risk being discharged from the practice.

You are responsible for keeping your appointments. A confirmation phone call is a courtesy that we provide when time permits.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred at this office.

Patient Name (Print): _____

Patient Signature: _____

Parent/Legal Guardian Name (if patient under 18 years of age): _____

Parent/Legal Guardian Signature (if patient under 18 years of age): _____