PATIENT REGISTRATION AND AGREEMENT

Three other phone numbers of friends, relatives or neighbors
1)
2)
3)

Marvel Clinic
1821 N. Washington St.
Tullahoma, Tennessee 37388

PATIENT IDENTIFICATION – Please Print

PATIENT'S LAST NAME	FIRST	MIDDLE
STREET ADDRESS	APT NO.	SOCIAL SECURITY NO.
CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	MARITAL STATUS SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___ SEPERATED ___
DATE OF BIRTH MO /DAY /YEAR	AGE	
PATIENTS OCCUPATION	EMPLOYER'S NAME	ADDRESS
PERSON TO NOTIFY (NAME & ADDRESS OF RELATIVE OR FRIEND)		TELEPHONE NUMBER
REFERRED BY	ADDRESS	

FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE FOR ACCOUNT FIRST MIDDLE I. LAST __ MR __ MRS __ MISS		REALTIONSHIP TO CLIENT
ADDRESS CITY STATE ZIP		
HOME PHONE	BUSINESS PHONE	
EMPLOYER	EMPLOYER ADDRESS	
SPOUSE	NAME OF SPOUSE'S EMPLOYER	

I, the undersigned, hereby authorize The Physicians and Healthcare Specialists at The Marvel Clinic to take before and after photographs of areas in which cosmetic surgery will be performed. I also understand these photographs may be shown to other potential patients whom are considering cosmetic surgery. Confidentiality and professionalism will be maintained by the physician and his staff.

I, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by myself and members of my family for services rendered. Failure to make a payment when requested or agreed is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable attorney fee and hereby waive their rights of exemption under the laws of the State of Tennessee and any other state. I understand the fees of The Physicians and Healthcare Specialists at The Marvel Clinic may exceed the amount paid by my insurance. I understand that the terms are cash at the time of services and that I will be given a complete insurance voucher and receipt signed by the doctor on the same day of each office service. I agree to pay 1 ½ percent interest charge/month on any outstanding balance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE THE PHYSICIANS HEALTHCARE SPECIALIST AT THE MARVEL CLINIC TO FURNISH INFORMATION TO INSURANCE CARRIERS, CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

______________________________ DATE

______________________________ WITNESS ____

(SIGNED) (SEAL)