eterna
vein & medical aesthetics

PATIENT INFORMATION (Please print)

Patient's Name _____

☐ Male ☐ Female

Last First MI

Birth date _____ Social Security # _____

Preferred language _____

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unspecified ☐ Declined to Provide

Race (select 1 or more) ☐American Indian ☐Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander (NHOPI) ☐ White

☐ Declined to provide

PATIENT INSURANCE DISCLOSURE (bring all insurance cards and picture ID with you on the day of your appointment)

I authorize Eterna Vein & Medical Aesthetics, PLLC, to release to my insurance company any information regarding my diagnosis and treatment by Eterna Vein & Medical Aesthetics, PLLC, necessary to process my insurance claim. I assign payment of medical benefits to Eterna Vein & Medical Aesthetics, PLLC. I understand services provided by Dr. Kim and his staff will be billed to insurance.

PATIENT, PARENT OR GUARDIAN SIGNATURE _____DATE _____

DO YOU HAVE A LIVING WILL? YES_____ NO_____
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? YES_____ NO_____

The existence or execution of a living will, durable power of attorney for health care or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.

SIGNATURE _____ DATE_____

MEDICARE PATIENTS ONLY – LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Eterna Vein & Medical Aesthetics, PLLC, for any services furnished me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____DATE: _____