

# Revalla Plastic Surgery

**Lisa M. Hunsicker, MD, FACS**

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Phone (720) 283-2500 • Fax (720) 283-1122

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Phone: \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Email \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Emergency Contact (person to be notified in case of emergency)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### PLEASE READ AND SIGN THE FOLLOWING

I represent to the physician and staff of Revalla Plastic Surgery that I am at least 18 (eighteen) years of age, or if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and/or treatment by Dr. Lisa M. Hunsicker and such assistant or staff as may be assigned by her. I understand that photography is a necessary part of planning and evaluating cosmetic and reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by her. In the event of any litigation arising from treatment, I agree to submit the case to arbitration.

I acknowledge there is a consultation fee for the initial visit with Dr. Lisa M. Hunsicker which is due at the time of my appointment unless other arrangements have been made.

I accept financial responsibility for all fees related to care I receive and agree to pay all charges that are not paid by insurance or third party payor. Should emergency care be necessary, I authorize the release of pertinent medical information to my insurance carrier as well as insurance benefits to be paid directly to Revalla Plastic Surgery. I understand that expenses related to complications from elective procedures may not be covered by insurance and that I am responsible for all non-covered services and/or any balance not paid by insurance.

I understand that a \$50 service charge plus additional costs for collection is assessed on all returned checks. The new balance is due within 10 days. Accounts that become delinquent either by returned check or non-payment for more than 30 days will be subject to collections service and will be assessed a 1.5% (\$5 minimum) monthly finance charge plus all collection company, court costs and reasonable attorney fees incurred.

\_\_\_\_\_  
**Signature of Patient** Date \_\_\_\_\_

\_\_\_\_\_  
**Signature of Guardian and Person Responsible for Payment for all Patients under 18** Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_