MAGNOLIA MEDICAL & AESTHETICS

INFORMED CONSENT

Insurance Verification & Billing

I herby authorize MAGNOLIA MEDICAL & AESTHETICS, acting as Service agent for **Doctor Louis H. Esquivel** and The MAGNOLIA MEDICAL & AESTHETICS (Facility), to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by both **Dr. Esquivel** and medical staff providing treatments under his supervision. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization To Release Medical Information For Billing

- I herby authorize the release of any information regarding services by the Physician/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims.

Assignment Of Insurance Benefit

- I herby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the physician and the facility made directly to the physician and/or the facility.

Financial Responsibility

- I understand that I am utilizing an "out of network" provider for the services rendered by the physician and facility. Therefore I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered. I agree to collect charges which will be added to my past due accounts.

Authorization For The Release Of Medical Information For Treatment

- I herby authorize the above physician and facility to obtain and release copies of my medical records and information regarding my medical history, mental or physical conditions for the purpose of further treatment and evaluation.

Patient Name:

Insurance Name: **Relationship to Patient:**

Insured Birth Date: **SSN #:** **Employer:**

Insured Address

Address of Employer: **City:** **State:** **Zip:**

Insurance Type: ( )PPO ( )POS ( )HMO ( )MEDICARE ( )MEDICAL ( )Other_____

Primary Insurance: _____ **Any Secondary** Insurance (if so, please state): _____

Group Policy # _____ **Certificate #** _____

Amount of Deductible? _____ **How much is met?** _____

Patient Name **Date** **Insured Signature**