Randall J. Falconer, MD

Accents

FACIAL PLASTIC SURGERY

Highly capable, dedicated care for natural-looking results.

Date_____

Name_____Sex___M/F Date of birth_____

Address_____City_____State_____ZIP_____

e-mail address_____ [ ] please add me to your e-mail list

Phone (home)_____(work)_____(cell)_____

Preferred number to contact you: home [ ] work [ ] cell [ ]

Employer/occupation_____

Spouse or partner's name_____phone number_____

Emergency contact (other than above) _____phone number_____

How did you hear about our services? _____

If a friend told you about us, whom may we thank?

_____

Do you have any friends that would like to be on our e-mail list to receive special offers?

Who is your primary health care provider? _____phone_____

What is your primary pharmacy? _____phone_____

Payment information

Accents facial plastic surgery is a division of Randall J Falconer MD PC. Cosmetic or aesthetic treatments provided by Dr Falconer are **not** covered by any insurance plans. By signing this agreement, I agree not to submit claims to my health insurance and I accept full responsibility for payment. I understand that payment in full is expected at the time of service. If this account is assigned to an attorney or collection agency, the practice shall be entitled to reasonable fees and costs of collections. This agreement shall remain in effect until revoked in writing. A photocopy of this agreement is considered to be as valid as an original.

I understand and agree to the above responsibilities: