PINK
Plastic Surgery

Windy A. Olaya, MD
P 714-564-9225
F 855-230-1459

PATIENT INFORMATION

Name: _____ DOB: _____

SSN: _____

Cell Phone: _____ Home Phone: _____

Address: _____ Zip: _____

Email: _____

Emergency Contact

Name: _____ Phone number_____

OTHER PROVIDER INFORMATION

Primary Care MD: _____ Phone # _____

Pharmacy: _____ Phone # _____

Referring MD: _____ Phone # _____

RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

———- (initial) I hereby authorize Windy A. Olaya, MD to release any and all medical information needed to process my insurance claim or for utilization review and financial audit. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Windy A. Olaya, MD.

———- (initial) Bills are ONLY sent by email, please provide information.

———- (initial) Appoint reminders are only done via text message. I understand that if I am late for an appointment, I may have to wait. If I am 15m late for an appointment, I may be rescheduled.

———- (initial) I know it is my responsibility to make sure my insurance information is up to date and correct. I understand I will be liable for all charges not covered by the insurance.

Pateint's Signature: _____ Date: _____

* Patient is Spanish Speaking and this form was translated by Griselda Rameriz _____