PATIENT CONFIDENTIAL INFORMATION

GENERAL INFORMATION

PATIENT'S NAME _____ BIRTHDATE _____ AGE _____ SEX _____

HOW WOULD YOU LIKE US TO ADDRESS YOU? _____

☐ CHILD ☐ SINGLE ☐ MARRIED

IF PATIENT IS A MINOR - PARENT'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ SOCIAL SECURITY # _____

CELL PHONE _____ WORK PHONE _____

WHICH NUMBER MAY WE CALL YOU TO CONFIRM APPOINTMENTS _____

EMAIL _____

WOULD YOU LIKE TO RECEIVE OUR QUARTERLY EMAIL NEWSLETTER? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

EMPLOYMENT INFORMATION

OCCUPATION _____ BUSINESS PHONE _____

EMPLOYER'S NAME & ADDRESS _____

_____

RELATIVE INFORMATION

☐ SPOUSE OR ☐ PARENT'S NAME (IF PATIENT IS A MINOR) _____ HOME PHONE _____

SPOUSE OR PARENT'S ADDRESS _____

SPOUSE OR PARENT'S EMPLOYER NAME & ADDRESS _____

_____ WORK PHONE _____

NAME AND ADDRESS OF CLOSEST RELATIVE OTHER THAN SPOUSE _____

CHILDREN'S NAMES AND AGES _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US?

_____ DOCTOR (NAME) _____

_____ OTHER PATIENT/FRIEND (NAME) _____

_____ YELLOW PAGES (WHICH ONE?) _____

_____ INTERNET (WHICH WEB SITE?) _____

_____ OTHER _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ EMPLOYER NAME & ADDRESS _____

INSURANCE COMPANY ADDRESS _____

SUBSCRIBER NAME _____ BIRTHDATE: _____ SUBSCRIBER SOCIAL SECURITY # _____

INS. CO. PHONE # _____ POLICY # _____ GROUP # _____

SECONDARY INSURANCE CO? _____ EMPLOYER NAME & ADDRESS _____

INSURANCE COMPANY ADDRESS _____

SUBSCRIBER NAME _____ BIRTHDATE: _____ SUBSCRIBER SOCIAL SECURITY # _____

CREDIT INFORMATION

Please read the Financial Policies section of our office brochure for information about payment policies. **We also request that you read and sign the reverse of this page.** We would be happy to answer any questions you might have regarding our policies.

AUTHORIZATION

I hereby authorize Plastic Surgery Specialists to furnish information to my insurance carrier concerning my examination, findings, and treatments. I understand that I am responsible for any amount of charges not covered by insurance. I authorize my insurance company to pay medical benefits to Plastic Surgery specialists for services and supplies described on my insurance form.

Patient's signature (or parent, if patient is a minor) _____ Date: _____

PLEASE COMPLETE OTHER SIDE

OUR POLICY

We are committed to providing you with the best possible care. If you have insurance coverage, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

Payment for services is due at the time services are rendered, and payment of your bill is considered part of your treatment. We accept cash, checks, MasterCard, Visa, and Discover. We also accept CareCredit. Additionally we well be happy to assist you with processing an insurance claim for your reimbursement. As a courtesy to you, we will forward the billing/insurance form to your insurance company or to your home. So as not to impose a financial burden on you, payment for surgical services ***covered by insurance***, and not already paid in advance, is due within 60 days following surgery.

Generally, for surgery with insurance involvement, we attempt to obtain preauthorization in writing from your insurance company. Based on their reply, we will estimate your out of pocket expense for such things as unmet deductible and co-insurance, which we ask you to pay two weeks in advance of your surgery. Please remember these are **estimates** only, and we cannot guarantee what the final surgical fee will be, as that fee is based on complexity and duration of your surgery. Nor can we be sure how your insurance company will reimburse for our services as we are an "Out-of-Network" provider with all insurances. It is your responsibility to be aware of all your insurance company's requirements before surgery (i.e., second opinion, hospital precertification, etc.) and to inform us of these stipulations well in advance of your surgery date.

Please realize that your insurance contract is between you, your employer (if they are providing the coverage), and the insurance company. ***We are not a party to that contract.*** Our fees generally fall within the acceptable range of most insurance companies. This applies to companies who determine payment based on "usual and customary" fees, meaning our fees are considered to be "usual and customary" by most insurance companies. However, if *your* company reduces the fees charged, due to their interpretation of usual and customary, this does not mean the doctor has overcharged. Some insurance companies have their own in-house schedule of fees, which bears no relationship to the current standard and cost of care in this area. Your insurance company may be trying to control their costs by limiting your benefits. Keep in mind that while the filing of insurance claims is a courtesy that we extend to you, all charges are your responsibility, regardless of your insurance company's determination of usual and customary.

If payment is not made and collection action becomes necessary, you are responsible for all costs of collection including reasonable attorney fees and court costs.

Our Patient Information Brochure can further clarify these policies for you, but if you have any questions, *PLEASE* request our assistance.

I have read the above, as well as the Patient Information Brochure provided by Plastic Surgery Specialists, P.C., and I understand the policies as stated.

_____ _____

Patient or responsible party Date

PLEASE ALLOW FOR DAYCARE AS CHILDREN WILL NOT BE PERMITTED IN EXAM ROOMS. THANK YOU!

PLEASE COMPLETE REGISTRATION ON THE OTHER SIDE