PATIENT FINANCIAL/INSURANCE INFORMATION SHEET

PATIENT: First Name: _____ Middle Initial: ____ Last Name: _____

SS# (last 4 digits only) _____ E-MAIL (Responsible Party's if patient under 18) _____

Street/**Mailing** Address: _____

City: _____ State: _____ Zip: _____ HomeTel: (____) _____
Work Tel: (____)_____
Employer: _____Full Time/Part Time Cell Tel: (____) _____

**** **If attending college**** School: _____ State:___ Full or Part time?

****

****SEND STATEMENTS FOR PATIENT BALANCES TO: If statements go to the patient, please write "Same"**

Name**:**_____ Daytime phone (if different than patient): (____) _____

Relationship to patient:_____ SS#:_____ Birthdate: _____ Employer:_____

Street (if different from patient): _____ City: _____ State: _____ Zip:_____

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PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

****WHO IS THE <u>POLICY HOLDER</u> FOR YOUR PRIMARY (main) INSURANCE?**

__patient __spouse of the patient (complete information below) ___parent of the patient (complete information below)

Holder's name:_____ Birthdate:_____ Sex____ SS#_____
Is this insurance through an employer group? _____ Employer name: _____

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****ARE YOU COVERED BY A SECONDARY OR SUPPLEMENTARY INSURANCE?**

The policy holder for this insurance is:

__patient __spouse of the patient (complete information below) ___parent of the patient (complete information below)

Holder's name:_____ Birthdate:_____ Sex____ SS#_____
Is this insurance through an employer group? _____ Employer name:_____

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FEES AND PAYMENTS;

We make every effort to keep down the cost of your plastic & reconstructive surgical care. If you have medical insurance, we will be glad to complete and submit the proper forms, but we will need the identifying information at top of this form. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**
I REQUEST/ AUTHORIZE PAYMENT OF MEDICARE, MEDIGAP PLANS AND ALL OTHER INSURANCES OF COVERED BENEFITS be made in my behalf directly to the physician named on the HCFA claim form.

SIGNATURE: _____**DATE:** _____ **APPOINTMENT DATE**:_____

PLEASE READ AND SIGN THE CREDIT AND PAYMENT POLICY ON THE REVERSE***