

PATIENT FINANCIAL/INSURANCE INFORMATION SHEET

\*\*PATIENT'S NAME:

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security # \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

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?

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\*\*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 POLICY HOLDER FOR YOUR PRIMARY (main) INSURANCE?

\_\_patient \_\_spouse of the patient (complete information below) \_\_parent of the patient (complete information below)

Holder's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_

Is this insurance through an employer or group? \_\_\_\_\_ Employer or Group 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: \_\_\_\_\_ SS# \_\_\_\_\_

Is this insurance through an employer or group? \_\_\_\_\_ Employer or Group 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: \_\_\_\_\_

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