RENUE PLASTIC SURGERY

Plastic and Reconstructive Surgery

2500 Starling Street, SUITE 603 ~ BRUNSWICK, GA 31520

PATIENT INFORMATION — Today's DATE:

Last **First** **Middle**

Social Security #: / /

Home Address **City/State/Zip**

Mailing Address *(if different from above)* **City/State/Zip**

Home Phone: _____ **Work Phone:** _____ **ext:** _____
(parents # if minor)

Cell Phone: _____ **Pager:** _____ **Marital Status:** **M** **S** **D** **W** *(circle one)*

Birth Date: _____ **Age:** _____ **Sex:** **Male** **Female** *(circle one)*

Patients' Occupation: _____ **Employer:** _____

Employer Address: _____ **Employer Phone:** _____
City *State* *Zip*

Spouse or Guardian Name: _____ **Employer:** _____

Employer Address: _____ **Employer Phone:** _____
City *State* *Zip*

EMERGENCY CONTACTS

In Case of Medical Emergency – First Contact
Name: **Relationship:** **Phone:**

Nearest Relative NOT Living With You
Name: **Relationship:** **Phone:**

Nearest Friend NOT Living With You
Name: **Phone:**

WHOM MAY WE THANK FOR REFERRING YOU TO US?

My Doctor
Name/Address: **Phone:**

Other *(circle one)* **Friend, Family, Yellow Pages/Bell South, PeachPages, Web Site, Worker's Compensation, Radio, Newspaper, Other:**

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured's Name *(if different from Patient)*: _____ **DOB:** _____
Policy Number: **Group Number:**

Secondary Insurance Company: _____

Insured's Name *(if different from Patient)*: _____ **DOB:** _____
Policy Number: **Group Number:**

DOES YOUR INSURANCE COMPANY NEED TO BE NOTIFIED IF YOUR SURGERY OR HOSPITAL ADMISSION US NECESSARY? **YES** **NO**

(Please turn page over)

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION REGARDING OFFICE POLICY

AUTHORIZATION FOR SERVICES

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to Renue Plastic Surgery for any services furnished me by the party/physician who accepts assignment. I understand it is mandatory to notify the health care provider for any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USA 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company or a related Medigap claim. I permit copy of this authorization to be used in place of the original.

Patient Signature:_____ Date:_____

PAYMENT POLICY

Renue Plastic Surgery and staff are committed to providing our patients with the best possible care. IF you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

All services are provided for a fee for service basis unless you are associated with a managed care plan. In the case of a managed care plan, you will be required to pay your co-pay only. Payments for office visits, insurance co-payments and deductibles **are expected when the service is rendered.** We accept cash, personal checks or credit cards.

AUTO ACCIDENTS / OTHER ACCIDENTS ~ When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, **the patient is responsible for payment of the bill.** Renue Plastic Surgery cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid. We will file your private insurance

WORKER'S COMPENSATION ~ Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their **PANEL OF PHYSICIANS**. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in without this information, we will have to ***reschedule*** the appointment. This information is necessary to avoid the patient being responsible for the bill.

MEDICAID ~ PLEASE bring a copy of your Medicaid card to each visit; otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits.

MEDICARE ~ We are a participating provider and will file your secondary insurance as a courtesy. If you have not met your deductible, we will expect the allowable charge of your visit to be paid at the time of your visit. If you do not have a secondary insurance, you will need to pay the 20% of the allowable charges.

INSURANCE ~ Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to pre-pay your unmet deductible and co-insurance prior to any surgery performed or following emergency services.

You will continue to receive a statement each month even though your insurance is pending. Renue Plastic Surgery cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call Renue Plastic Surgery, and ask for the someone to assist you with your account.

If you need to set up an extended payment arrangement, contact someone in our Insurance Department. This payment agreement **does not pertain to elective surgery procedures.** If no payment has been received **after 90 days** from the date the services were rendered, necessary collection procedures will begin.

I HAVE READ AND UNDERSTAND THE ABOVE CONTRACT.

Patient Signature:_____ Date:_____