

## PIEDMONT PLASTIC SURGERY AND DERMATOLOGY

Patient name:		Date of birth:	Date:
Address:		City/State/Zip:	
Email address		Social Security #	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Home phone:	Cell phone:	Employer:	
Marital status:	Spouse Name:	Referring Doctor:	Primary Doctor:
Emergency Contact:	Relationship:	Phone #: (H):	(C):
Responsible Party:	Relationship:	Date of birth:	Social Security #:
Responsible Party Address:		City/State/Zip:	Phone #:

### INSURANCE INFORMATION

<b>Primary Insurance:</b>		Employer:	<b>Secondary Insurance:</b>		Employer:
Insurance ID #:		Insurance Group #:	Insurance ID #:		Insurance Group #:
Insurance Address:			Insurance Address:		
City/State/Zip:			City/State/Zip:		
Insured Name:			Insured Name:		
Insured Date of birth:		Insured Social Security #:	Insured Date of birth:		Insured Social Security #:

**Referral (How did you hear about our office?):**

Physician \_\_\_\_\_ Previous Patient \_\_\_\_\_ Yellow Pages, City \_\_\_\_\_  
 Magazine \_\_\_\_\_ Website \_\_\_\_\_ Other \_\_\_\_\_

**IF YOU WOULD LIKE TO SET UP A FREE CONSULTATION WITH ONE OF OUR PHYSICIANS REGARDING ANY OF THE FOLLOWING PLEASE CIRCLE AND LET US KNOW.**

- Facial Aging    •Skin Care Products    •Spider Veins    •Tummy Tuck    •Restylane    •Eyelifts    •Botox
- Breast Augmentation    •Facelift    •Ear Surgery    •Nose Surgery    •Radiance    •Laser Hair Removal    •Liposuction
- Mole Removal    •Spa Services    •Chemical Peel    •Thread Lift    •Breast Reduction    •Dysport    •Latisse

**Financial Responsibility and Assignment of Insurance Benefits:**

Piedmont Plastic Surgery & Dermatology believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice. **PAYMENT is expected on the same day of each visit prior to the physician encounter.** We accept cash, checks, Visa, MasterCard, Discover and American Express. PAYMENT will include any unmet deductible, co-insurance, co-payment amount, prior balance, cosmetic or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. RETURNED CHECKS will incur a \$25.00 service charge. We are participating providers for most insurance carriers. We will file all primary and secondary insurance claims for you. We do NOT file with third parties but will provide you with the information for you to do so. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Piedmont Plastic Surgery & Dermatology.** Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees. I hereby authorize and direct my insurance carrier to issue payment check directly to Piedmont Plastic Surgery and Dermatology for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

<b>Signature of Patient:</b> _____	<b>Date:</b> _____
<b>Signature of Authorized Person:</b> _____	<b>Date:</b> _____

**Consent for Healthcare and Release of Medical Information:**

I authorize Piedmont Plastic Surgery and Dermatology to use and disclose the health and medical information of for the purposes of Treatment, Payment and Health Care Operations. You may review Piedmont Plastic Surgery and Dermatology's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request. As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice. I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Piedmont Plastic Surgery and Dermatology has already used or disclosed the information in reliance on this consent.

<b>Signature of Patient:</b> _____	<b>Date:</b> _____
<b>Signature of Authorized Person:</b> _____	<b>Date:</b> _____