

PITTMAN PLASTIC SURGERY P.C.

Please fill out form completely - Do not leave any spaces blank - If it does not apply, please write in, "N/A"

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Address (Personal): _____

City/State/Zip: _____

Address (Mailing if different): _____

City/State/Zip: _____

Date of Birth: ____/____/____ Age: _____ SSN: _____

Male Female Marital Status: Married Single Divorced Separated Widowed

Employer: _____

Work Telephone #: _____ Home Telephone #: _____ Cell #: _____

Phone # to be reached at: _____

Email Address: _____

May we notify you via email of any specials/upcoming events? Yes No

Name of person or physician who referred you: _____

Have you previously been a patient? Yes No If so, approximately when? _____

Please list any family members to whom we may disclose information: _____
(i.e. account balance, pathology reports, appointment information, etc.)

RESPONSIBLE PARTY INFORMATION (Please fill out this information if patient is under 18 or a full-time student.)

Name: _____
Last First Middle Initial

Address (Personal): _____

City/State/Zip: _____

Address (Mailing if different): _____

City/State/Zip: _____

Date of Birth: ____/____/____ Age: _____ SSN: _____

Male Female Marital Status: Married Single Divorced Separated Widowed

Employer: _____

Work Telephone #: _____ Home Telephone #: _____ Cell #: _____

Email Address: _____

May we notify you via email of any specials/upcoming events? Yes No

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Work Telephone #: _____ Home Telephone #: _____

(Continued on back)

PITTMAN PLASTIC SURGERY P.C.

INSURANCE INFORMATION

Insurance Company: _____

Address: _____

City/State/Zip: _____

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____ Insured's SSN _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE

Insurance Company: _____

Address: _____

City/State/Zip: _____

Insured's Name: _____

Insured's Date of Birth: _____/_____/_____ Insured's SSN _____

Policy #: _____ Group #: _____

AUTHORIZATION OF TREATMENT

I authorize the medical treatment which has been or will be rendered to me or my dependent, as named above, by Dr. C. Edwin Pittman and/or Dr. James A. Parker.

ASSIGNMENT OF BENEFITS

I understand that I am the responsible party for any charges incurred. Should I elect to have insurance filed on my behalf, I certify that I presently maintain medical insurance coverage which will reimburse Dr. Pittman/Dr. Parker/Center for Plastic & Reconstructive Surgery for the care provided. In consideration of services rendered or to be rendered, I hereby assign, transfer, and set over to Dr. Pittman/Dr. Parker/Center for Plastic & Reconstructive Surgery all of my rights, title, and interest to medical reimbursement. I authorize the release of any medical and/or billing information to insurance carriers to facilitate the processing of medical claims. This assignment of benefits is irrevocable and extends to the total amount owed to Dr. Pittman/Dr. Parker/Center for Plastic & Reconstructive Surgery. A photocopy of this assignment is to be considered as valid as the original.

MEDICARE WAIVER/FINANCIAL RESPONSIBILITY

I understand that Medicare will only pay for services that it determines to be reasonable and medically necessary under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service is not "reasonable and medically necessary" under Medicare standards, Medicare will deny payment for that service(s). I have been notified that Medicare may deny payment for services rendered and I understand and agree that I am responsible for payment of services rendered.

Regardless of my insurance benefits, I understand that I am responsible for the total charges for services rendered and I agree to be responsible for any reasonable collection cost and/or court attorney's fees incurred in the collection of this account. I understand that if my account reaches collection status, I will be assessed interest at 1.5% monthly on any outstanding balances until paid in full. I authorize Dr. Pittman/Dr. Parker/Center for Plastic & Reconstructive Surgery to conduct a credit investigation, including employment verification, should this be necessary.

PHOTOGRAPH RELEASE

I authorize the use of all photographs taken of me for any medical purpose deemed appropriate by my physician. I authorize the release of pre- and post-operative photographs to referring physicians and appropriate insurance carriers.

HIPAA POLICY

I have read and understood the HIPAA Policy and Privacy Statement and may receive a copy upon request.

Signature of Patient/Responsible Party

Date

Witness Signature

Date/Time

PLEASE PROVIDE INSURANCE CARDS AND DRIVER'S LICENSE TO BE COPIED