

PATIENT DEMOGRAPHIC INFORMATION

PLEASE COMPLETE AND MAKE CORRECTIONS AS NECESSARY

| | | |
|---------------|-------------|-----------------------------|
| ACCOUNT # -25 | | DATE OF BIRTH: |
| LAST NAME: | HOME PHONE: | PATIENT AGE: |
| FIRST NAME: | | GENDER: |
| MI: | CELL PHONE: | MARITAL STATUS: Unspecified |
| ADDRESS: | _____ | SOCIAL SECURITY NUMBER: |
| CITY: | | E-MAIL: |
| STATE: | | _____ |
| ZIP: | | INS. CARDHOLDER'S NAME: |
| EMPLOYER: | WORK PHONE: | INS. CARDHOLDER'S DOB: |
| ADDRESS: | | _____ |
| CITY: | _____ | INS. CARDHOLDER'S SSN: |
| STATE: | | |
| ZIP: | | |

EMERGENCY CONTACT NAME (OTHER THAN SPOUSE): _____

RELATIONSHIP: _____ PHONE NO: () _____ - _____

IF INJURY, HOW DID ACCIDENT HAPPEN? _____

IS THIS WORK RELATED? _____ DATE OF INJURY: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SSN _____

EMPLOYER: _____ PHONE NO: () _____ - _____

CITY: _____ STATE: _____ ZIP: _____

All office visits are due and payable on the date service is rendered. If you have an insurance company that Heartland Plastic & Hand Surgery is a participating provider with, you will be responsible for paying your co-pay the day of your visit. A claim will then be submitted for you. No claim will be submitted for any cosmetic services, such as; Skin Care, Laser Treatments, Surgery, etc..

It is our policy to file all insurance claims for surgeries or hospitalizations. It is your responsibility to furnish our office with your insurance information. This office cannot accept responsibility for collecting your insurance claim or negotiating the settlement of a disputed claim since we are not a party to your insurance contract. You will be responsible for any non-covered services as stated by your insurance company. In accidents, legal cases, etc., where a third party is presumed liable for your medical expenses, the party receiving medical services is responsible for payment. This office cannot be expected to wait for court conclusions or disputed insurance claim settlements.

In cases of workers compensation, we must have an authorization from your employer or the workers comp carrier. If your claim is denied, you are responsible for payment of medical services provided.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims and also to release to any physician that I request.

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefit, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE: _____ DATE: _____

PRIVACY NOTICE ACKNOWLEDGEMENT: I hereby acknowledge that I have received and been given the opportunity to ask questions regarding the facility's Notice of Privacy Practices.

SIGNATURE: _____ DATE: _____