Pittman Plastic Surgery P.C.

Please fill out form completely.

Patient Information

Name: _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address (physical): _____

City / State / Zip: _____

Mailing Address (if different): _____

City / State / Zip: _____

Date of birth: _____ / _____ / _____ Age: _____ SSN: _____

❑ Male ❑ Female Marital status: ❑ Married ❑ Single

Employer: _____

PLEASE LIST ONLY THE PHONE NUMBERS YOU WISH TO BE CONTACTED AT AND THAT WE ARE AUTHORIZED TO LEAVE A MESSAGE

Telephone numbers: WORK _____ HOME _____ CELL _____

Best phone number to be reached at: _____

May we notify you via email of any specials/upcoming events or test results: ❑ Yes ❑ No

Email address: _____

How did you hear about our office? ❑ Physician ❑ Patient ❑ Internet ❑ Radio ❑ Other: _____

Name of person or physician who referred you: _____

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

I authorize you to speak with the following person(s) on my behalf: | If a name is listed, but no boxes are marked, you are authorizing us to discuss ALL matters with that person(s).

_____ Relationship _____ Phone # _____

OK to discuss: ❑ Appointments ❑ Test results ❑ Billing information

_____ Relationship _____ Phone # _____

OK to discuss: ❑ Appointments ❑ Test results ❑ Billing information

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Emergency Contact Information

Name: _____ Relationship to patient: _____

Work telephone # : _____ Home telephone#: _____ Cell #: _____

Financially responsible Party *(complete only if patient is under 18 or a full-time student)*

Name: _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address (physical): _____

City / State / Zip: _____

Mailing Address (if different): _____

City / State / Zip: _____

Date of birth: _____ / _____ / _____ Age: _____ SSN: _____

❑ Male ❑ Female Marital status: ❑ Married ❑ Single

Employer: _____

Telephone numbers: WORK _____ HOME _____ CELL _____

(CONTINUED ON BACK)

Pittman Plastic Surgery P.C.

Name: _____

PLEASE PROVIDE INSURANCE CARD AND YOUR DRIVERS LICENSE

Primary Insurance Information

Insurance company: _____

Policy holder's name (if different than patient): _____

Policy holder's date of birth: _____ / _____ / _____

Secondary Insurance

Insurance company: _____

Policy holder's name (if different than patient): _____

Policy holder's date of birth: _____ / _____ / _____

Authorization of treatment

I authorize the medical treatment which has been or will be rendered to me or my dependent, as named above, by C. Edwin Pittman, M.D.

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 Plastic Surgery of Athens, PC / 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 Plastic Surgery of Athens, PC / 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 Center for Plastic & Reconstructive Surgery. A photocopy of this assignment is to be considered as valid as the original.

Medicare and Insurance Waiver

It may be necessary to release your protected health information to insurance companies, financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

I undertand that Medicare and/or other Insurance Companies will only pay for services that they determine to be reasonable and medically necessary. Medicare is covered under Section 1862(a)(1) of the Medicare law. If Medicare and/or Insurance Companies determine that a particular service is not "reasonable and medically necessary" under their standards, they will deny payment for that service(s). I have been notified that Medicare and/or other Insurance Companies may deny payment for services rendered. 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 Plastic Surgery of Athens, PC / Center for Plastic & Reconstructive Surgery to conduct a credit investigation, including employment verification, should this be necessary.

CREDIT CARDS, DEBIT CARD, AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Plastic Surgery of Athens, PC / Center for Plastic & Reconstructive Surgery to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

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 _____