Piedmont Plastic Surgery, PA

PLEASE HAVE YOUR INSURANCE CARD(S) AND PHOTO ID READY TO BE COPIED

GROUP INSURANCE INFORMATION

Primary Insurance:_____ Member ID:_____

Policyholder Name: _____ Policyholder Date of Birth:_____

Group #: _____Patient's Relation to Policyholder: (CIRCLE ONE) Self Wife Husband Child Parent Other

Secondary Insurance:_____ Member ID:_____

Policyholder Name: _____Policyholder Date of Birth: _____

Group #: _____Patient's Relation to Subscriber: (CIRCLE ONE) Self Wife Husband Child Parent Other

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____Relationship: _____

Home Phone: ( )_____ Work: ( )_____ Cell: ( ) _____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW

Parent/Guardian/Guarantor Name: _____

Address:_____

(if different from above) Street City State Zip Code

Home Phone: ( ) _____ Work: ( )_____ Cell: ( ) _____

Social Security #: _____ Date of Birth: _____ Sex: M ____ F ____

Marital Status: (CIRCLE ONE) Single Married Widowed Divorced Separated

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The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment: I** consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information: I** authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits: I** authorize payment of medical benefits to Piedmont Plastic Surgery, PA

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Piedmont Plastic Surgery PA for charges not covered by insurance.

_____ _____

Signature of Patient, Guardian or Legal Representative Date