

Lambeth Plastic Surgery & Aesthetics, P.A.
PATIENT INFORMATION

Chart # _____

PLEASE FILL OUT FORM IN ITS ENTIRETY

How did you learn about our office? _____

Patient's Name: _____ Birthdate: ____/____/____ Age: _____ Sex: _____
Last First Middle M D YR

Patient's Address: _____
Street Apt# City State Zip Code

Patient's SS# _____ Phone (H): _____ (WK): _____ ext. _____ Cell _____

Employer: _____ Employer Address: _____

At which telephone number may we discreetly reach you if necessary? _____

Would you like to receive information regarding special offers? Yes No

Send to: Home Address or Email address _____

Is this a work related injury? Yes No Is this an attorney referred appointment? Yes No

Are you the Primary Insurance Holder?: Yes No

If you checked NO, information below MUST be completed.

Primary Policy Holders Name: _____ SS# _____ DOB: _____
Employer: _____

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I _____ acknowledge that a copy of our Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Signed _____ Date _____

(Patient Signature or Responsible Party)

*******INSURANCE COVERAGE/BENEFIT NOTIFICATION***** VERY IMPORTANT - PLEASE READ*******

If your procedure is an insurance reimbursable case, we will be glad to file your insurance for you. Your employer and/or individual insurance plan you have chosen dictates your deductible and coinsurance. Given that we contract with your insurance company, we **are required** to collect all deductibles and coinsurance due associated with the procedure you are having performed. **Your "Specialist" office visit co-pay does not apply for your surgery, only for your initial doctor visit.** If you have any questions regarding your outstanding deductible and/or surgical co-pays, please consult your insurance company prior to scheduling surgery.

Authorization and Assignment

I hereby authorize Lambeth Plastic Surgery & Aesthetics, P.A. , to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and/or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits is due the day of service and if insurance submitted for surgical services is not paid by 60 days, I must pay in full unless arrangements are made. I consent to be photographed and understand that the photographs are necessary for my treatment and/or determination for insurance benefits. The photographs will not be used for advertising purposes.

Patient (or legal representative) Signature: _____ Date: _____

Relationship to Patient (if legal rep.) _____