PIEDMONT PLASTIC SURGERY & DERMATOLOGY
www.ppsd.com

Demographic/Insurance Form

MR#

Patient Name		Date of Birth	Date
Is patient in a skilled nursing facility, inpatient facility, or a nursing home? ☐ Yes ☐ No If yes, please provide facility address below: Facility phone number_____ Contact name_____		_____	
Address		City/State/Zip	
Email		Social Security	Sex: ☐ Female ☐ Male Ethnicity
Home Phone	Cell Phone	Employer	
Marital Status	Spouse Name	Referring Doctor	Primary Doctor
Emergency Contact Not In Household	Relationship	Home Phone	Cell Phone
Responsible Party If Not Self	Relationship	Date of Birth	Social Security
Responsible Party Address		City/State/Zip	Phone

INSURANCE INFORMATION

Primary Insurance	Employer	**Secondary Insurance**	Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insurance Address		Insurance Address	
City/State/Zip		City/State/Zip	
Name of Policy Holder	Relationship to Patient	Name of Policy Holder	Relationship to Patient
Policy Holder Date of Birth	Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Social Security #

Referral (How did you hear about our office):

☐ Est. Patient ☐ Employee ☐ Magazine_____ ☐ Billboard_____
☐ Physician _____ ☐ Radio _____ ☐ TV _____
☐ Web-Facebook ☐ Web-Google ☐ Web-Landing Page ☐ Web-Instagram ☐ Web-PPSD ☐ Web-Twitter ☐ Web-Yahoo ☐ Other

If you would like to set up a FREE consultation regarding any of the following, please check box:

☐ Botox/Xeomin/Dysport	☐ Chemical Peels	☐ Facial Redness	☐ Laser Hair Removal	☐ Spider Veins
☐ Blotchy Skin	☐ CoolSculpting	☐ Fine Lines/Wrinkles	☐ Liposuction	☐ Tummy Tuck
☐ Breast Reduction	☐ Drooping Eyelids	☐ Hair Restoration	☐ Nose Size/Shape	☐ Volbella
☐ Breast Augmentation	☐ Ear Size or Shape	☐ Juvederm/Restylane/Radiesse	☐ Skincare Advice/Products	☐ Voluma
☐ Brown Spots	☐ Eyelash Length/Fullness	☐ Kybella	☐ Spa Services	☐ Other

Financial Policy and Assignment of Insurance Benefits:

Be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient. I hereby authorize and direct my insurance carrier to issue payment check directly to Piedmont Plastic Surgery & Dermatology for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges. I agree that if my insurance carrier sends payment to me for the medical services instead of to PPSD, I will immediately pay the amount due to PPSD. I agree it is my responsibility to understand my insurance benefits and to notify Piedmont Plastic Surgery & Dermatology immediately of any changes to my insurance coverage. I understand that it is my responsibility to obtain insurance authorization if it is required and the payment is still my responsibility. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Piedmont Plastic Surgery & Dermatology.** I agree for Piedmont Plastic Surgery & Dermatology to service my account or to collect any amounts I owe, I may be contacted by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also receive text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize review, recording and downloading of my prescription history records from the internet and/or other doctors' data or pharmacy(ies). I also authorize photography of my medical/surgical conditions. Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees. There will be a charge for form completion: disability, FMLA, supplemental insurance, etc. The forms require office staff time and time away from patient care for the physicians. We require 3 business days to complete the forms and requests. I authorize Piedmont Plastic Surgery & Dermatology to use and disclose the health and medical information for the purposes of Treatment, Payment and Health Care Operations. You may review Piedmont Plastic Surgery & Dermatology's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Signature of Patient _____ **Date**_____

(If patient is under 18 years of age, a parent or legal guardian must sign.)

Signature of Piedmont Plastic Surgery & Dermatology Authorized Personnel_____ **Date**_____

NOTE: IF YOU HAVE MEDICARE, PLEASE COMPLETE BACK OF FORM

Please Sign So We May Have Your Medicare Authorization On File

I authorize as the holder of medical or other information about me to release to the Social Security Administration and health care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date____/____/____ Signature _____

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Are you in a Medicare HMO or other Senior Medicare Plan? ☐ Yes ☐ No

If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Name of Insurance Company _____

Policy Number_____ Group Number _____

Name Policy Holder (Insured)_____ ☐ Male ☐ Female Date of Birth ___/___/____

Supplemental Insurance or Medicare Advantage Plans

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan, which covers the 20% NOT covered by Medicare.

Name of Insurance Company _____

Policy Number_____ Group Number _____

Name Policy Holder (Insured)_____ ☐ Male ☐ Female Date of Birth ___/___/____

Please Sign So We May Have Your Supplement Authorization On File

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

Date____/____/____ Signature _____

Please present your Medicare and insurance card(s) and a photo ID to the receptionist along with this completed form.

Answer questions below by placing a check in the appropriate column:

YES	NO	
☐	☐	Have you recently joined a Medicare Advantage Plan? If yes, identify: _____
☐	☐	Do you or your spouse work in a company that has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by a commercial HMO/PPO that makes Medicare secondary?
☐	☐	Is this illness covered by the VA (Veterans Administration)?
☐	☐	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Are you receiving Medicaid?