PIEDMONT PLASTIC SURGERY & DERMATOLOGY
www.ppsd.com

MR#

DATE

Demographic/Insurance Form

Patient Name			Date of Birth
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
Preferred 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 #

Acknowledgement of Office Policies for Piedmont Plastic Surgery & Dermatology (PPSD)

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.

Cancellation/No-Show Policy/Late Policy: It is the patient's responsibility to contact the office at least 24 business hours in advance to cancel regularly scheduled visits. Patients who do not call at least 24 business hours prior to their scheduled appointment and/or fail to keep their appointment will be considered a "no-show." Patients with three consecutive "same day" canceled or "no-show" appointments within a 6-month period may be discharged from the practice. Patients who arrive at PPSD more than 15 minutes after their scheduled appointment time will be considered late and may be required to reschedule their appointments.

Consent to Treatment: I voluntarily consent to the performance of diagnostic exams and procedures provided by the medical provider and/or their staff as deemed necessary. I also understand that photographs may be taken in the course of treatment. I authorize photography of my medical/surgical conditions. No guarantees have been made to me regarding the result of treatments by my caregivers.

I authorize review, recording and downloading of my prescription history records from the internet and/or other doctors' data or pharmacy(ies).

I understand if I have a surgical procedure or biopsy performed there will be at least two charges. The first is for the provider collecting the biopsy and the second is for the examination of the specimen. It is possible that a specimen may be sent out to another lab if needed. In the event that my biopsy is sent to an outside laboratory, a separate bill may be sent to me from this outside laboratory for their pathology charges. PPSD will provide the outside laboratory with billing/insurance information for

PIEDMONT PLASTIC SURGERY & DERMATOLOGY
www.ppsd.com

MR#

DATE

Demographic/Insurance Form (cont.)

the outside laboratory to process these charges. 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. PPSD requires 3 business days to complete the forms and requests.

Cosmetic Consult: I understand if I am scheduled for a cosmetic consult at no charge and I would like to discuss medical issues that are considered non-cosmetic, I will be informed that the visit is no longer a cosmetic consult. PPSD will need my insurance information to proceed. Applicable copays, deductibles, and coinsurance will apply to the visit.

I authorize PPSD to use and disclose the health and medical information for the purposes of Treatment, Payment and Health Care Operations. I understand that I may review PPSD's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Acknowledgement of Office Policies for Piedmont Plastic Surgery & Dermatology (PPSD)

Consent for Filing Insurance Claims: I hereby authorize and direct my insurance carrier/Centers for Medicare and Medicaid (CMS) services to issue payment directly to Piedmont Plastic Surgery & Dermatology (PPSD) for medical services rendered to myself and/or my dependents. I authorize the release of any relevant information to my insurance company. I authorize my provider's office to act as my agent in assisting me to obtain payment from my insurance company. I permit a copy of this authorization to be used in place of the original, and request payment of medical payment of medical insurance benefits for myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. 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 also authorize payment of any Medigap benefits on my behalf to PPSD for services provided to me.

Medicare: PPSD is a participating provider of the Medicare program. PPSD will accept assignment on all claims. I am responsible for meeting my annual deductible and paying for the 20% coinsurance. PPSD does file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 60 days, I will be balance billed.

Payment: All copays, deductibles, and coinsurance are collected at the time of service. As a courtesy, PPSD will file claims to all insurance carriers for medical services. I understand that it is my responsibility to determine if PPSD is a network provider for my insurance carrier. 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 PPSD 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. I am aware that insurance is a contract between me and the insurance company and ultimately, I am responsible for payment in full to PPSD. I agree for PPSD 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 understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account may be referred to our collection agency. I understand I will be responsible for all cost including fees, attorney fees, and court fees.

I understand that if I do not have health insurance, $125 deposit if due at the time of service unless other arrangements have been made. I understand that I will be billed or refunded the difference between the deposit amount and any occurred charges at each visit.

Returned Checks: I understand that returned checks will incur a $25 insufficient funds fee per check. I will be required to bring cash or a money order to cover the amount of the check, PLUS the fee.

NOTICE: By electronically signing your name on this form, you are (i) confirming that you are the party listed at the top of this form, and (ii) agreeing that your typed signature is the legal equivalent – and carries the same force and effect – of your written signature for this specific document. After signing electronically, you will have the option to print a fully executed copy of this form. You also have the right to: (1) sign the form in our office; (2) withdraw your electronic consent at any time through written notice to us; and (3) obtain a paper copy of this form.

Date____/____/____ Signature _____