PLASTIC SURGERY ASSOCIATES PATIENT INFORMATION

PATIENT'S FULL NAME_____ DATE_____

ADDRESS_____ E-mail _____
NO. & STREET CITY STATE ZIP

HM PH # (_____) _____ WK PH # (_____) _____ CELL # (_____) _____

PATIENT'S AGE_____ BIRTH DATE _____/_____/_____SS# _____/_____/_____

SEX: ❑ M ❑ F MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED SPOUSE NAME_____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____
NO. & STREET CITY STATE ZIP

REFERRED BY _____ NAME OF FAMILY PHYSICIAN _____

NAME OF RELATIVE OR CLOSE FRIEND NOT LIVING WITH YOU _____

HM. # (_____) _____ RELATIONSHIP TO PATIENT _____

REASON FOR TODAY'S VISIT _____

DUE TO INJURY? INJURY DATE _____/_____/_____ ON THE JOB? _____ AUTO ACCIDENT? _____

RESPONSIBLE PARTY (If different from patient)

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR _____

ADDRESS_____
NO. & STREET CITY STATE ZIP

HM PH # (_____) _____ WK PH # (_____) _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

NAME OF INSURED _____ NAME OF INSURED _____

DATE OF BIRTH _____/_____/_____ DATE OF BIRTH _____/_____/_____

SSN _____/_____/_____ SSN _____/_____/_____

RELATIONSHIP OF PT. TO INSURED _____ RELATIONSHIP OF PT. TO INSURED _____

EMPLOYER NAME _____ EMPLOYER NAME _____

NOTICE OF PRIVACY PRACTICE: I have received my copy of the ***Notice of Privacy Practice*** from Plastic Surgery Associates.

_____ DATE_____
PATIENT SIGNATURE

METHOD OF PAYMENT FOR TODAY'S SERVICE: ❑ CASH ❑ CHECK ❑ CREDIT CARD

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Plastic Surgery Associates. I transfer my title of reimbursement from my insurance company to a doctor of Plastic Surgery Associates. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize my insurance claim form to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

SIGNATURE: _____ DATE: _____

WITNESS: _____

PLASTIC SURGERY ASSOCIATES
Landon S. Perry. M.D.
*Plastic & Reconstructive Surgery * Aesthetic Surgery*

NOTICE TO PATIENTS

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please review carefully the information contained in this notice.

1. During the course of our physician/patient relationship, I may refer you to Physicians Medical Center, L.L.C. d/b/a Texas Health Center for Diagnostics & Surgery Plano ("**Hospital**") or one or more other physicians who provide specialized medical services.

2. I want to inform you that I am very aware of the services provided at this Hospital because I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services that physician also could have an ownership interest in the Hospital.

3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than the Hospital or physicians to whom I might refer you from time to time.

4. I will not be treating you differently if you choose to obtain health care at a facility other than the Hospital and, if you desire, I will be happy to provide you information about alternative health care providers.

If you have any questions, please do not hesitate to ask. We welcome you as a patient, and we value our relationship with you.

By signing below you acknowledge that you have read and understand this notice, and that you are aware of my ownership interest in the Hospital. Should you be referred to the Hospital or to another physician who holds an ownership interest in the Hospital, you acknowledge your decision to decline the option to have your health care provided at another health care facility. You further acknowledge that you signed this notice prior to my referral of you to the Hospital or another physician.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Printed Name

_____
Date

PLASTIC SURGERY ASSOCIATES

Landon S. Perry. M.D.
*Plastic & Reconstructive Surgery * Aesthetic Surgery*

WAIVER OF LIABILITY, MEDICALLY UNNECESSARY AND NON-COVERED SERVICES RELEASE FORM

Plastic Surgery Associates agrees to make every effort to be sure that all claims filed on your behalf will be filed

I hereby agree to be personally and fully responsible for payment of all services that my insurance company may deem as "medically unnecessary, cosmetic, pre-existing, not pre-certified or preauthorized" or otherwise "not covered" under the terms of my insurance plan.

I understand that this waiver applies to any type of insurance plan, including all PPO, Managed Care and Medicare Plans.

My signature below indicates that I DO UNDERSTAND that I MAY receive a statement (bill) in the mail from Plastic Surgery Associates after I have received services and that should my insurance company not cover these services that I AM FIANANCIALLY RESPONSIBLE to pay this balance due in a timely manner.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Witness Signature

_____

Date