# *Northeast Florida Plastic Surgery Center*
# *New Patient Information Form*

***(Please Print)***

***Patient Information:***

| Last Name: | Home Phone: |
|---|---|
| First Name: M.I. | Work/Cell Phone: |
| Address: | Social Security: |
| City,State,Zip | Date of Birth: |
| Employer/School: | Driver's License#: |
| Occupation: | E-mail: |

***Responsible Party Info:***

| Last Name: | Home Phone: |
|---|---|
| First Name: | Work/Cell Phone: |
| Address: | Social Security: |
| City,State,Zip | Date of Birth: |
| Employer: | Relationship to Patient: |

***Who May We Thank for Referring You?*** ***Procedure***

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| *Authorization #* | *Wisits* | *Exp:* |
|---|---|---|
| | | |

***Insurance Info: Primary*** ________________ ***Secondary:***

| Name: Name: | |
|---|---|
| ID#: | ID# |
| Group# | Group# |
| Phone# | Phone # |
| Address: | Address: |

## NORTHEAST FLORIDA PLASTIC SURGERY CENTER

## FINANCIAL POLICY

Our relationship with you is based on rendering the best possible care and a clear understanding of our financial policy.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc. Our professional services are rendered to you not the insurance company, therefore payment for services is your responsibility. If you have a referral based HMO/PPO/POS insurance plan it is your responsibility to insure you have a valid referral upon each visit. Not all services are covered benefits in all contracts. Please understand that if your insurance does not pay for a service you will be responsible for payment in full. It is your responsibility to understand your plan benefits. ~ Your deductible and co-pays are due a time of visit.

We will file with and accept assignment from your primary insurance company only if we participate with your insurance plan. It is your responsibility to insure that we have a copy of your current insurance card on file. We do not file insurance with or accept assignment from plans that we are not contracted with unless emergency surgery is necessary. It is your responsibility to notify us of any changes in your insurance.

* If you are self-pay, please be prepared to pay in full at the time services are rendered.
**(Cosmetic Surgical Consultations are $75.00)**

* ________________ Initial

Patient's balances are billed monthly. You are responsible for timely payment of any patient balance. We take cash, check, money order, Visa, Master Card, and Discover. All returned checks are subject to a $35.00 return fee. We realize that temporary financial problems may affect timely payments on your account. If such problems arise we encourage you to contact us to make other payment arrangements. Patients account balances older than 60 days are subject to collection procedures.

~ ________________ Initial

I authorize Northeast Florida Plastic Surgery Center to bill my insurance company directly for services and direct payment of benefits to Northeast Florida Plastic Surgery Center that otherwise would be payable to me.

~ ________________ Initial

In addition, I authorize Dr. Eric A. Weiss to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents all information with regard to my medical care.

~ ________________ Initial

**Acknowledgment: I have read and understand the above Financial Policy.**

Signature Date