PLASTIC SURGICAL ARTS
The Beauty of Transformation

Patient's Information

Today's Date:_____/_____/_____

Name:_____ Sex: M / F
Last First MI

Date of Birth:____/____/_____ Soc Sec#:_____ -_____ -_____ Marital Status: S / M / D / W

Home Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ Apt#_____ City: _____ State____ Zip:_____

Employer: _____ WorkPhone: (_____)_____

Email: _____ Reason for Consult:_____

How did you hear about us? (Please Circle one) Website Physician Referred: _____

Google Other_____

Friend/Family Member_____

- Race:
  - White
  - African American
  - Asian
  - Other
  - Native American Indian / Alaskan
- Ethnic Group:
  - Not Hispanic / Latino
  - Hispanic / Latino
  - Decline to Answer
- Primary Language:
  - English
  - Spanish
  - Other

Person Responsible for Bill - (if different from patient)

Name:_____ Sex: M / F
Last First MI

Date of Birth:____/____/_____ Soc Sec#:_____ -_____ -_____ Marital Status: S / M / D / W

Home Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ Apt#_____ City: _____ State____ Zip:_____

Employer: _____ Work Phone: (_____)_____

Emergency Contacts - Please include someone who does NOT live with you.

Name:_____ Phone:_____Relationship:_____

Name:_____ Phone:_____Relationship:_____

Patient's Insurance Information ***(The accuracy of this information is extremely important in the processing of your claims. Inaccuracies will result in the patient being responsible and billed for services rendered)***

1. Primary Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: ____/_____/_____ Subscriber's SS#: _____ - _____ - _____ Relationship: _____

2. Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: ____/_____/_____ Subscriber's SS#: _____ - _____ - _____ Relationship: _____

If you intend for us to send this claim to insurance, you will be responsible for co-pays, co-insurance, deductible, etc per your plans requirements.

If you intend for this visit to be self-pay, or are consulting today for acosmetic procedure, you do not need to complete this section.

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for services furnished to me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing . I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Plastic Surgical Arts.

X_____

Signature of Patient or Guardian if patient is 18 or under

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Financial Policies

01/01/2022

While our primary concern at Plastic Surgical Arts, is your health and well being, it is also necessary to address financial issues associated with your care. Please note the following policies of Plastic Surgical Arts.

Payment Policies

- Most insurance plans require that you pay a deductible, co-insurance and/or co-pays. Co-pays are due at the time of your appointment and co-insurance, deductibles, and other out of pocket ***expenses are expected at the time of service***.
- Payments may be made with cash, check, or by credit/debit card.
- Returned checks will result in a $35 processing fee.

Insurance Policies

- Your insurance plan is a contract between you and your insurance provider and we comply with those contracts, billing insured the required amounts dictated by the insurance plan as stated on the explanation of benefits that both you and this office receive for the services provided.
- If your insurance provider fails to make payments within a timely period (60 days), payment in full is expected from the patient or responsible party.
- Failure to respond to an insurer's request for information may result in a claim denial. Should this occur, the balance becomes the responsibility of the patient.
- It is your responsibility to review your individual plan as some procedures may not be covered by your insurance plan, in which case, you will be fully responsible for the cost.

Global Period

- A "global period" may be assigned to your procedure. The surgical global period includes the actual surgery and uncomplicated follow up care. In most cases minor office procedures have a 10 day global period and 90 days for more complex surgeries. After the global period, any continued care will be billed. Also, you may still incur costs during your global period due to complications, supplies, or other services unrelated to the surgery.

Other Charges

- Please be aware that there may be charges from others involved in your care, such as assistant surgeons if applicable, the facility in which your surgery is performed, your anesthesiologist, or pathology/laboratory fees if applicable.

Additional Questions

- Should you have any questions or concerns regarding our financial policies, please don't hesitate to call us at 402-483-2572 or visit with our office staff.

Acknowledgment

I have been given a copy of Plastic Surgical Arts' Financial Policy. My signature certifies that I have read and understand the financial policy of Plastic Surgical Arts.

- **I understand that fees are due at the time of service and that I will be required to provide a credit or debit card for automatic payment in addition to signing a separate financial agreement should I be unable to pay in full at the time of service.**
- **I understand that I will be responsible for any remaining balance once the claim has been processed by my insurance plan.**
- **I understand that it is my responsibility to inform Plastic Surgical Arts of any changes regarding my insurance coverage and that failure to do so may result in my being responsible for the full balance.**
- **I have been given a copy of this agreement and agree to its terms.**

Responsible Party's Printed Name

Todays Date

Responsible Party's Signature

Relationship to Patient

Acknowledgment of Privacy Practices

I, _____, have received a copy of Plastic Surgical
(print patient name)

Arts Notice of Privacy Practices.

(The portion below is optional. Fill out only if you want others to be able to obtain/discuss your medical records)

I, _____, give permission to the following person(s) to obtain or discuss any/all of my medical information.

Name: _____, Relationship: _____

Name: _____, Relationship: _____

Name: _____, Relationship: _____

Name: _____, Relationship: _____

☐ Yes, I am giving permission to the individuals listed above to discuss and/or obtain protect-ed health information about myself/patient and I understand that I may revoke this permis-sion in writing at any time.

☐ No, I do not want to give anyone permission to discuss or obtain protected health information other than the physicians and medical facilities involved in my care.

_____
Patient/Guardian Printed Name

_____
Patient/Guardian Signature

_____
Patient's Date of Birth

_____
Today's Date