SPOKANE PLASTIC SURGEONS P.S.

Beauty Through Excellence

PATIENT

Legal Name: _____
Last First MI

Gender: **M** **F** Date of Birth: _____ Age: _____ SSN: _____

Address: _____
Street City State Zip

Home PH: _____ Cell PH: _____ Work PH: _____

_____ YES _____ NO Is it ok to leave a message any number listed above?

Email Address: _____ How did you hear about us: _____

Marital Status _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Race/Ethnicity: _____ American Indian or Alaska Native _____ Asian _____ Native Hawaiian or Pacific Islander

_____ White _____ Black or African American _____ Hispanic or Latin _____ Other _____

What is your Primary Language? _____

Do you have any Special Needs? _____ Language _____ Mobility _____ Other, please list _____

Are you a Student? _____ Yes _____ No _____ Full Time _____ Part Time

Are you employed? _____ Yes _____ No _____ Full Time _____ Part Time

Name of Your Employer: _____

Emergency Contact: _____ Ph: _____

Relationship: _____ OK to release information?: _____ Yes _____ No

Do you have a Primary Care Physician? _____ No _____ Yes Name: _____

SPOUSE

Name: _____ Date of Birth: _____ SSN: _____

Employer Name: _____ PH: _____

MINOR

Parent or Guardian Name: _____ Date of Birth: _____ SSN: _____

Address: _____
Street City State Zip

Home PH: _____ Cell PH: _____ Work PH: _____

INSURANCE

Primary Insurance Name: _____ Secondary Insurance Name: _____
Subscriber's Name: _____ Subscriber's Name: _____
Subscriber's Date of Birth _____ Subscriber's Date of Birth _____
ID# _____ Group# _____ ID# _____ Group# _____
Relationship to Patient: _____ Relationship to Patient: _____

* Is this a work related injury? If YES – Claim # _____ and Date of Injury: _____

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ASSIGNMENT OF BENFEFITS, PAYMENT TERMS AND RELEASE OF INFORMATION

INSURANCE PAYMENT TERMS

Medicare/Medicaid/Other Government Programs/Private Insurance: If you qualify for benefits under Medicare, Medicaid, a government program or private insurance company, you authorize the program(s) to make payment directly to Spokane Plastic Surgeons, PS for your care. You also authorize Spokane Plastic Surgeons, PS to release all relevant information about you and your health care necessary to receive payment. You are responsible to pay deductible, co-insurance and spend down under such insurance program(s). COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

Payment Terms: While we have agreed to accept assignment of benefits from governmental health care programs and certain insurance companies, you remain personally responsible for payment in full for billed charges, unless otherwise required by law. You acknowledge that failure to meet your obligations according to Spokane Plastic Surgeons, PS financial policies will result in the referral of your account to a professional collection agency.

Paperwork Completion Charges: You may be subject to a charge for filling out paperwork (such as FLMA/AFLAC forms) that is bought in from employers and/or insurance companies. These charges range between $10.00 to $25.00 depending on the length of the form.

Right to Revoke Authorization: You have the right to revoke your authorization for Spokane Plastic Surgeons, PS to release information about you and your health to government programs and/or insurance companies. Your revocation must be in writing and will be effective when it is received by the practice. If your revocation results in denial of payment to Spokane Plastic Surgeons, PS you are responsible to pay for the care provided.

COSMETIC PAYMENT TERMS

Cosmetic Procedure: I understand the procedure(s) I am interested in will **not** be billed to my private medical insurance. I am/will be responsible for all costs, including surgeon fee, operating room, anesthesia, miscellaneous supplies and/or implants, and/or fillers.

Surgery Quote: My Surgical quote will expire four (4) months from the date it is written.

Surgery Scheduling: I acknowledge to schedule a surgery, there is a $500.00 scheduling fee required. The scheduling fee will be applied toward the cost of surgery. The scheduling fee is refundable up to one (1) month prior to surgery.

Cancelation of Surgery: If surgery is canceled within the one (1) month time limit, Spokane Plastic Surgeons, PS may retain the $500.00 scheduling fee. If the surgery date is postponed within two (2) weeks of the original surgery date, the scheduling fee may transfer to the new date.

Cosmetic Surgery along with Insurance Covered Procedure: I understand the prepayment in full is due two (2) weeks before my cosmetic surgery does not include out of pocket costs (deductible/coinsurance) assigned to pay Spokane Plastic Surgeons, PS by my insurance for the covered procedure.

I have read and understand Spokane Plastic Surgeons, PS "**Cosmetic Payment Terms".**

I have read and understand Spokane Plastic Surgeons, PS "**Assignment of Benefits, Payment terms, and Release of Information".**

Signature: **Date:**

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SKIN CARE & INJECTION PROCEDURE Financial Agreement

I understand the procedure(s) I seek are cosmetic in nature, not medically necessary, and therefore it would be fraudulent and unethical for Spokane Plastic Surgeons to submit a fee to any insurance company for coverage.

I have been shown and understand the financial costs of having Spokane Plastic Surgeons provide cosmetic services for me and accept these terms.

I further understand that Spokane Plastic Surgeons will not accept insurance for this (these) services(s).

My consent to have Spokane Plastic Surgeons provide services and not accept assignment from any insurance company, managed care provider, or other coverage source is irrevocable and final.

I understand I will be fully responsible for the surgical fees for the surgery I seek.

Patient Consent for Use of Credit Cards, Debit Card, and Financing - Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Spokane Plastic Surgeons to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

I agree that this non credit card challenge agreement is irrevocable.

_____ _____

Signature Date