

**PLASTIC SURGEONS OF THE HUDSON VALLEY
PATIENT INFORMATION**

Patient Name _____
Last First M.I.

Mailing Address _____
Street City State Zip Code

Phone _____ **Cell** _____

Email Address: _____

If you supply us with your email address, you are giving our office permission to email you directly.

Would you like to receive our newsletters? (Includes office info, specials and discounts) **Yes** **No**

Social Security No. _____ - _____ - _____ **Marital Status** _____

Age _____ M F **Date of Birth** _____

Spouse's Name _____ **Phone** _____

Insured's Social Security No. _____ - _____ - _____ **Insured's D.O.B.** _____

If patient is less than 18 years of age:

Parent/Guardian _____ **D.O.B.** _____

EMPLOYMENT INFORMATION

Your Employer _____ **Phone** _____

Address _____
Street City State Zip Code

Spouse's Employer _____ **Phone** _____

Address _____
Street City State Zip Code

DEMOGRAPHIC INFORMATION

Preferred Language: English Spanish Other: _____

Race: White
 Black/African American
 American Indian/Alaska Native
 Asian
 Native Hawaiian/Pacific Islander
 Other
 Patient Declined/Unknown

Ethnicity: Spanish/Hispanic Origin
 Not of Spanish/Hispanic Origin
 Patient Declined/Unknown

**Please bring your insurance card and driver's license to the window with your paperwork.
Thank you.**

INSURANCE INFORMATION

This section must be completed. The copy of your insurance card is for verification purposes only.

1. Primary Insurance Company _____

Group No. _____ Policy No. _____

2. Secondary Insurance Company _____

Group No. _____ Policy No. _____

PATIENT AUTHORIZATION

I hereby authorize the release of any medical and/or insurance information necessary to process any claims for services rendered by Plastic Surgeons of the Hudson Valley.

I hereby authorize the payment of my aforementioned medical benefits to the physician rendering services to me. I further authorize the payment of my aforementioned secondary and/or Medigap medical benefits to the physician rendering services to me.

POLICY INFORMATION

Our goal is to give each patient the care he/she needs within their appointment time. If extended care is needed or emergencies arise, we ask that you please be patient knowing that when you are with the doctor, you will also be afforded all the time necessary for your care.

Insurance cards cannot be altered in anyway and valid photo identification must be provided at time of appointment. If your insurance requires a referral, it is your responsibility to make sure that the referral is obtained prior to your appointment, or you will be responsible for the cost of your appointment at the time of service.

Cosmetic consult fee or copay is due at time of service.

Cosmetic procedure fees will be discussed with you at the time of your visit.

A \$25.00 fee will be assessed if you do not cancel your scheduled appointment at least 24 hours in advance.

Workers' Compensation and No Fault patients must have complete insurance information so that we can submit all of the necessary paperwork. It is your responsibility to supply us with all the correct information, including the insurance company, claim number, accident date, and a contact name and number for insurance company. . Failure to give us the information in a timely manner (45 days) will result in the patient being billed the full amount of services rendered. **Motorcycle accidents are not covered by No Fault.**

If we are required to take legal action to collect payment, you will be responsible for **any and all** fees associated with such action, including filing fees, attorney's fees and collections fees.

Please let us know if you have any questions or would like a copy of this form for your records. Thank you.

I understand that I am ultimately responsible for any charges regardless of my insurance. Plastic Surgeons of the Hudson Valley will make all reasonable attempts to obtain payment from my insurance company.

However, if these attempts fail, I understand that I will be am responsible for the charges.

Patient/Guardian Signature

Date