MURPHY PLASTIC SURGERY

PATIENT INFORMATION

Name: _____
First Middle Last

Address: _____ City: _____ State _____ Zip Code: _____

SSN: _____ - _____ - _____ Marital Status: S M D W DOB: _____ / _____/ _____ **Age:** _____ Sex: M F

Home phone: (_____) _____-_____ Work: (_____) _____-_____ Mobile: (_____) _____-_____

E-mail: _____ Preferred contact :(circle one) Home Work Mobile E-mail

Employment:

☐ Retired ☐ Disabled ☐ Student: P/T or F/T ☐ Employed: P/T or F/T ☐ Self-Employed ☐ Unemployed

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State _____ Zip Code: _____

Referral Source:

Name: _____ Phone: (_____) _____ - _____

Address: _____ City: _____ State _____ Zip Code: _____

Emergency Contact:

Name: _____ Relationship to pt: _____

Phone: (_____) _____ - _____ Work: (_____) _____-_____ Mobile: (_____) _____-_____

RESPOSIBLE PARTY (If different from patient)

Name: _____ Relationship to pt: _____

Address: _____ City: _____ State _____ Zip Code: _____

Phone: (_____) _____ - _____ Work: (_____) _____-_____ Mobile: (_____) _____-_____

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State _____ Zip Code: _____

INSURANCE INFORMATION

Were you in an auto accident? Y N Were you injured at work? Y N Other Accident: Y N **Date of Injury:** _____

For Auto and Work injuries only:

Insurance Name: _____ Claim Number: _____

Address: _____ City: _____ State _____ Zip Code: _____

Adjuster Name: _____ Phone: (_____) _____ - _____

Primary Insurance

Name: _____ Policy No: _____ Group No: _____

Address: _____ City: _____ State _____ Zip Code: _____

Subscriber's Name: _____ Phone: (_____) _____ - _____
First Middle Last

Address: _____ City: _____ State _____ Zip Code: _____

DOB: _____/ _____/_____ SSN: _____ - _____ - _____ Sex: M F Relationship to pt: _____

Employer Name: _____ Phone: (_____) _____ - _____

Secondary Insurance

Name: _____ Policy No: _____ Group No: _____

Address: _____ City: _____ State _____ Zip Code: _____

Subscriber's Name: _____ Phone: (_____) _____ - _____
First Middle Last

Address: _____ City: _____ State _____ Zip Code: _____

DOB: _____/ _____/_____ SSN: _____ - _____ - _____ Sex: M F Relationship to pt: _____

Employer Name: _____ Phone: (_____) _____ - _____

FINANCIAL POLICY

Due to problems experienced with some insurance companies and patients not paying for services in a timely manner our office has no choice but to inform our patients of the following financial information. An account is considered past due thirty (30) days following billing unless other arrangements have been made. Unpaid accounts beyond ninety (90) days are considered delinquent and will be forwarded to our collection agency. In the event that an account should have to be turned over to a collection service for non-payment by a patient or responsible party, the collection service cost will be added to the total amount owing on the account as an administrative charge.

Nevada State Insurance Laws require health insurance companies to pay medical claims within sixty (60) days of receipt of the claim. Our office submits claims generally within one or two days of services being rendered. We highly recommend that you keep in touch with your insurance company to ensure that timely and proper payment of your medical claims, are made. **Unpaid insurance accounts beyond 90 days will be forwarded to you for payment**. Your insurance coverage is a contract between the employer/patient and their insurance company, and regardless of insurance coverage the patient is ultimately responsible for the billed charges.

HMO/PPO patients: Your co-pay is due at the time of service. If your insurance requires AUTHORIZATIONS for office visits, it is the patient's responsibility to contact their Primary Care Physician (PCP) for proper referral/authorization. **If we do not have an authorization at the time of visit, your appointment will be rescheduled.** As a courtesy we will bill your insurance for you; however because some insurance companies consider some procedures as "cosmetic in nature" patients will be responsible for 100% of any services that the insurance deems cosmetic. Patient/ Responsible Party is also responsible for 100% of any services they decide to have that are not "authorized" or limited by your insurance plan.

Medicare patients: Please be aware that some of the services provided may be non-covered services or considered not medically necessary under the Medicare program. You will be required to sign an Advance Beneficiary Notice (ABN) for any services rendered by our office.

Phone Calls to the Doctor

Our doctor will not be doing telephone medicine, if you need to talk to the doctor we will schedule you an appointment.

Missed Appointments

Unless cancelled at least twenty four (24) hours in advance, we reserve the right to charge $50.00 to your account for all missed appointments. Please help us to serve you better by keeping scheduled appointments, or courtesy call to cancel your appointment several days ahead of time (if possible), so that we can fill that appointment time with other patients who are waiting to be seen.

Returned Check Policy

A $25.00 service charge will be added to your account on all returned checks.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorized the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

FINANCIAL AGREEMENT AND ACKNOWLEDGEMENT

I hereby authorize Northern Nevada Plastic Surgery to furnish to the above insurance companies or to a designated attorney all information which said insurance companies or attorney may request. I authorize payments of my medical benefits from my insurance company to NNPSA. I understand that co-payments are due at the time of visit and I am financially responsible for any balance my insurance does not cover/pay. In the event legal action should become necessary to collect any unpaid balance, I agree to pay all collection fees and/or court cost and legal fees required. I hereby acknowledge that I have read, completed and understand the: Patient Information Form, Financial Policy, and Medical Records Release.

Signature: _____ **Date:** _____/_____/_____