Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
Diplomates American Board of Plastic Surgery
www.associatedplasticsurgeons.com
864 West Jericho Turnpike
West Hills, NY 11743.
Tel: 631-423-1000
Fax: 631-271-6900

Date _____

Name (First, Last) _____

Address _____

City, State, Zip _____

Home Phone _____

Business Phone _____

Date of Birth _____

Social Security # _____

E-Mail _____

Sex _____ Marital Status _____

Referred by _____

Address _____

Phone # _____

Family Physician _____

Address or Phone # _____

If you have recently been treated by our doctors in the Emergency Room please fill in below:

Date of Emergency Room Visit _____

Hospital _____

Name of Treating Physician _____

Guarantor Insurance Information

Name of Guarantor _____

Address of Guarantor _____

Place of Employment _____

Employment Address _____

Employer Telephone _____

Insurance Company _____

Plan _____

Group # _____

Insured's Name _____

Insured Party ID# _____

Relationship _____

Insured Party SS# _____

If injury or consultation stems from a **work related** (compensation) injury, **car accident** (no-fault), or **third party insurance company** please notify the receptionist.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

We accept cash, checks, Visa or MasterCard. We will be happy to assist you in the processing of your insurance claim form. Any such request must be accompanied by a completed insurance form.

Returned checks and balances older than 30 days will be subject to additional collection fees. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. All legal fees associated with a delinquent account are the responsibility of the patient, parent or guardian. In the event that your account goes to collection, you will be responsible for a service fee of $250.00 or 33% on the unpaid balance. This fee is in addition to all legal fees previously mentioned. On all delinquent accounts greater than 60 days from the date services are rendered, interest may be charged at the rate of 1.25%/month.

You must realize, however, that if we do not participate with your insurance:

1. Your insurance is a contract between you, your insurance company and/or employer. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of the usual, customary and reasonable fees as determined by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits of all contracts. Some insurance companies arbitrarily select certain services that they will not cover. Cosmetic procedures are usually not a covered expense.
4 If you are insured with a company with whom we currently participate, please have your insurance ID card available for our information. Should this insurance company, for any reason, not reimburse us directly, or if we should not hear from this company in reference to a claim, you will be responsible for full payment.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Please be advised that a referral is needed for each visit. If your primary care physician has informed you that a referral is "in the system" be advised that if it cannot be retrieved, you will be held personally responsible for payment.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read all the information on this sheet. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I will notify you of any changes in my health insurance status.

I have received/been offered a copy of Privacy Regulations and Patient's Rights.

Signature _____

Please Print Name _____

Date _____