Plastic Surgery Center
5 Livingston Street Asheville NC 28801-4407
(828)254-4444 FAX: (828) 254-2423

Thank you for choosing our office. In order to serve you properly, **PLEASE PRINT** the following information.

Name:					**Chart #**
Address:			**City/State/Zip:**		
SSN:	**Birthdate:**	**Age:**	**Marital Status:**	**Gender:**	**Race:**
Home Ph:	**Work Ph:**		**Cell Ph:**	**E-mail:**	
Spouse(parent if minor):			**Spouse's Employer:**		
Any restrictions for contacting you:					
Employer:	**Employer's Address:**				
Occupation:			**Full/Part/Student/Retired/Other:**		
Emergency Contact Name:					**Relationship:**
ER Contact Home Ph:			**ER Contact Work Ph:**		
How did you hear about us:					
For what reason are you seeking treatment:					
Are you/your family previous patients at the Plastic Surgery Center:					
If patient is a child, who may authorize treatment:					**Relationship:**
Person financially responsible for treatment if not Self:					
Address of person financially responsible:					**Phone:**

Primary Insurance:	**Address:**	
Policyholder: **SS#:** **Date of Birth:**	**Policy No:** **Employer:**	**Group No:** **Employer Address:**
Secondary Ins:	**Address:**	
Policyholder: **SS#:** **Date of Birth:**	**Policy No:** **Employer:**	**Group No:** **Employer Address:**
If Workers Compensation, treatment authorized by:		**Claim #:**
If you authorize release of your medical information to anyone besides your insurance carrier, please give the name:		
If you have a telephone answering machine at home, may we leave messages there: YES☑ NO☐		

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature:	**Date:**

PLASTIC SURGERY CENTER
James M. McDonough, M.D. • David H. Humphreys, M.D. • Donald R. Conway, M.D. • Colette Stern, M.D.

5 Livingston Street at Victoria Road • Asheville • NC • 28801 • 828-254-4444 • Fax 828-254-2423

CONSENT TO TREAT AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I WISH to be treated by the above named physicians. While I am a patient, I permit my doctor(s) and their staff caring for me to treat me in ways they judge are beneficial to me. I understand this care may include tests, examinations, and medical treatment.

I AUTHORIZE the above named physicians to obtain or release any medical information necessary for treatment or for processing insurance claims for services provided.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of another date.

SIGNED:_____

DATE: _____

ADDRESS:_____

_____

AUTHORIZATION FOR PAYMENT OF BENEFITS

I AUTHORIZE that payment of medical benefits be made to the above named physicians on any claim submitted for service furnished me by that physician or organization.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of another date.

SIGNED:_____

DATE:_____

Billing of insurance on your behalf is provided as a courtesy by the Plastic Surgery Center. You are responsible for payment of your charges regardless of insurance coverage. If you are a member of a managed care insurance program, you should verify with your insurance carrier that they will pay for services provided by this office.

**********DO NOT WRITE BELOW THIS LINE**********

PATIENT INFORMATION UPDATES

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

_____

Signature or patient (or guardian) Date

****

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

_____

Signature or patient (or guardian) Date

****

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

_____

Signature or patient (or guardian) Date

****

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

_____

Signature or patient (or guardian) Date

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