Christiana Cosmetic Surgery Consultants

E-62 Omega Dr
Newark, DE 19713
(302) 368-9611

STRICTLY CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE _____

NAME _____AGE_____ BIRTH DATE _____ SS# _____

ADDRESS _____ E-MAIL _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE_____CELL PHONE_____WORK PHONE _____

MARITAL STATUS: S M W D SEP [ ] MALE [ ] FEMALE
EMPLOYMENT STATUS: [ ] FULL TIME [ ] PART TIME [ ] RETIRED [ ] UNEMPLOYED
ARE YOU A STUDENT? [ ] FULL TIME [ ] PART TIME [ ] NOT A STUDENT

YOUR EMPLOYER: _____ WORK PHONE NUMBER:_____

SPOUSE OR PARENT'S NAME: _____ SS# _____ BIRTH DATE _____

SPOUSE OR PARENT'S EMPLOYER _____WORK PHONE _____

PRIMARY CARE PHYSICIAN (PCP)_____ PHONE _____

PHARMACY NAME, ADDRESS & PHONE_____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

PERSON RESPONSIBLE FOR PAYMENT **(if not above)** _____
ADDRESS _____ PHONE _____

YOU MUST COMPLETE THE FOLLOWING STATEMENT

I authorize release of my protected healthcare information to: _____
Relationship:_____ Telephone number: _____
Can appointment reminders be left on your home answering machine? _____Yes _____No
Can messages asking you to call the office concerning healthcare information be left on answering machine? ____Yes ____No

INSURANCE INFORMATION

PRIMARY (1ST) INSURANCE

NAME OF INSURANCE COMPANY _____ PHONE _____
SUBSCRIBERS NAME _____ BIRTH DATE _____
ID or POLICY # _____ GROUP # _____ PLAN # _____
RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER_____

SECONDARY (2ND) INSURANCE

NAME OF INSURANCE COMPANY _____ PHONE _____
SUBSCRIBERS NAME _____ BIRTH DATE _____
ID or POLICY # _____ GROUP # _____ PLAN # _____
RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER _____

***YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CO-PAYS AND FEES REGARDLESS OF INSURANCE COVERAGE. ***

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that any authorized Medicare or other insurance company payments be made for me on my behalf to Christiana Cosmetic Surgery Consultants, Jonathan Saunders MD, Katheryn Warren MD and Julia MacRae MD for any services rendered to me by that party that accepts assignment. Regulations' pertaining to Medicare assignment of benefits does apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare or other insurance company claim.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance company.

Signature _____ Date _____

PLEASE REVIEW AND SIGN OUR FINANCIAL ON THE OTHER SIDE

[ ]I have received a copy of this office's Privacy Statement under HIPPA guidelines