The Plastic Surgery Institute of Washington

Aesthetic, Plastic and Reconstructive Surgery

Roger J. Friedman, MD, PC **Douglas L. Forman, MD, FACS** **Kathy Huang, MD**

Insurance Information

Date ____/____/____

Patient Name _____ Date of Birth ____/____/____ SS# _____-_____-_____

Subscriber's Name (if different than patient) Relationship to patient _____

First Name _____ Last Name _____ Date of Birth ____/____/____

Home Address _____ SS# _____-_____-_____

_____

Home Phone # (____) ____-_____ Mobile Phone # (____) ____-_____ Work # (____) ____-_____

Occupation _____ Employer _____

Employer Phone # (____) ____-_____ _____

Agreement to Pay for Treatment

The patient and responsible party listed hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payment and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers or payers.

Signature x_____ Date ____/____/____

Release and Statement to Permit Payment of Private Insurance Benefits to Provider

I (We), the undersigned patient and/or responsible party, hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I (We) authorize the release and disclosure of any and all of my medical records to any other entity, includig, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I (We) authorize the release of medical records necessary to assist in the reimbursement of benefits to which I (we) may be entitled. I (We) authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I (We) authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to the patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

Patient Signature x_____ Date ____/____/____

Subscriber Signature x_____ Date ____/____/____

Office Insurance Policy

Drs. Friedman and Forman only participate with Medicare and Dr. Huang only participates with Medicare and Blue Cross (as of 8/1/08). All other insurances are considered non-participating. We will bill on your behalf using your out-of-network benefits if your policy provides them. You are responsible for your deductible and co-insurance. We will be happy to assist in appeals if indicated.

Signature x_____ Date ____/____/____