ASSOCIATES IN
Plastic Surgery
Est.1978

8425 CUMBERLAND PLACE
BATON ROUGE, LA 70806

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☐ GARY W. COX, M.D.
☐ JOHN A. DEAN, M.D.
☐ ANDREW C. FREEL, M.D.

OUR OFFICE POLICY REQUIRES PAYMENT FOR OFFICE VISITS AT THE TIME OF SERVICE.

PLEASE CHECK PAYMENT METHOD FOR TODAY'S VISIT: CASH ☐ , CHECK ☐ , VISA ☐ , MASTERCARD ☐ , DISCOVER ☐ , AMERICAN EXPRESS ☐ , OTHER ______

PLEASE PRINT CLEARLY

DATE ______

PATIENT INFORMATION

PATIENT'S FULL NAME ______ DATE OF BIRTH ______ AGE ______ SEX ______

PT. ADDRESS ______ CITY ______

STATE ______ ZIP ______ HOME PHONE NO. ______ WORK PHONE # ______

EMAIL ADDRESS: ______ CELL PHONE # ______

MARITAL STATUS: ☐ Single ☐ Separated ☐ Married ☐ Divorced SOCIAL SECURITY NO. ______ DRIVER LICENSE NO. ______

EMPLOYED BY ______ ADDRESS ______

Who referred you to us? Physician ______ Friend/Relative ______ ☐ Yellow Pages ☐ Web ☐ Newspaper ☐ Magazine

NAME OF PERSON NOT LIVING WITH YOU TO BE NOTIFIED IN AN EMERGENCY ______

PHONE # ______

NAME OF SPOUSE (OR PARENT IF SINGLE) ______ SOCIAL SECURITY NO. ______

SPOUSE OR PARENT'S EMPLOYER ______ OCCUPATION ______

BILLING INFORMATION

WHO IS RESPONSIBLE FOR PAYMENT? ______

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ EMPLOYER ☐ OTHER

ADDRESS ______ CITY ______ STATE ______ ZIP ______

EMPLOYED BY ______ ADDRESS ______

CITY ______ STATE ______ ZIP ______ OCCUPATION ______

SOCIAL SECURITY NO. ______ DRIVERS LICENSE NO. ______

HOME PHONE # ______ EMPLOYER PHONE # ______

MEDICAL INSURANCE INFORMATION

DOES THE PATIENT HAVE MEDICAL INSURANCE? YES ______ NO ______

IS THIS VISIT DUE TO AN ACCIDENT? YES ______ NO ______ IF YES, AUTO? ______ OTHER? ______

DATE OF ACCIDENT ______

NAME OF **PRIMARY INSURANCE COMPANY** ______

MAIL CLAIM TO: ______ CITY ______ STATE ______

ZIP ______ INSURANCE CO. PHONE # ______

POLICY HOLDER'S NAME ______ RELATIONSHIP TO PATIENT ______

POLICY / ID CERTIFICATE # ______ GROUP / PAYOR # ______

POLICY HOLDER'S DATE OF BIRTH ______ POLICY HOLDER'S SOCIAL SECURITY # ______

NAME OF SECONDARY INSURANCE COMPANY ______

MAIL CLAIM TO: ______ CITY ______ STATE ______

ZIP ______ INSURANCE COMPANY PHONE # ______

INSURED NAME ______ RELATIONSHIP TO PATIENT ______

POLICY / ID CERTIFICATE # ______ GROUP / PAYOR # ______

SECONDARY HOLDER'S DATE OF BIRTH ______ SECONDARY HOLDER'S SOCIAL SECURITY # ______

WORKERS' COMP.

IS THIS VISIT DUE TO A JOB RELATED INJURY? YES ______ NO ______ DATE INJURED ______

* PLEASE FILL OUT WORKERS' COMP. FORM *

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay for all charges for such treatment. **WE REQUIRE THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

I agree that this office will prepare and file any insurance claim which I have in connection with treatment received, and I agree, as evidenced by my signature, to assignpayment of any applicable benefits payable to my insurance company to this office. A copy of this agreement will be considered as valid as an original. I also authorize the release of all information necessary to secure payment of my claim.

I understand the practice is not responsible for collecting payment from my insurance company. If the company delays or withholds payment of my claim, I will be responsible for direct payment. I am also responsible for any and all amounts which insurance does not pay, including any deductible amounts, coinsurance or charges not covered. I understand and agree that a service charge in the amount of 1.5% (one and one half percent) or 18% per annum will be assessed on the unpaid balance after 90 days from the date of service. If it becomes necessary to refer this account to an attorney or collection agency for collection, I am responsible to pay all reasonable collection agency and/or attorney fees and court costs.

I agree to be photographed before and after any surgical procedure and understand these photographs will remain the property of my treating physician.

SIGNATURE ______
Patient, Parent, or Legal Guardian

DATE ______

SIGNATURE ______
Other Account Guarantor