NEW PATIENT INFORMATION

PERSONAL INFORMATION (Please Print)

Name_____ Date_____

Date of Birth_____Age_____M/F____ Soc. Security # _____

Address_____

Street City State Zip

Phone: Home #_____ Work #_____Cell# _____

Employer_____ Occupation_____

Address_____ Phone#_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer_____

Address _____ Employer Phone #_____

Referred by: ☐ Friend/Relative _____ Doctor_____

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other_____

Complete if Under 18 years or a student

Name of Father_____ Employer _____

Date of birth _____ Soc. Security #_____

Address _____Phone #_____

Name of Mother_____ Employer _____

Date of Birth _____Soc. Security_____

Address _____ Phone #_____

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____

Workers Compensation (job injury) to whom is bill to be sent? _____

Other Medical Insurance _____

ID# _____ Group # _____

2nd Insurance _____

ID# _____ Group # _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____Relationship _____

Address_____

Home_____ Phone_____

Work#_____

By signing up for Email, you consent to receive electronic communications, promotional offers, event notices and other materials from Idaho Eyelid & Facial Plastic Surgery. If you have any questions, or should you wish to withdraw your consent at any time, please feel free to contact us 208-344-3220. You may also opt out of our emails at any time by clicking the unsubscribe link at the bottom of any email from us.

Signed _____ Email Address _____

☐ I would **ONLY** like to receive emails regarding my account and appointments.

FINANCIAL ASSIGNMENT AND AGREEMENT

1. **We always request payment at time of service**. **If appointment is missed without 24 hour notice there is a $50.00 charge.**
2. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
3. In order to control your cost of billings, we request that your charges for office visits, including deductibles & copays, be paid at the conclusion of each visit. If we are required to use Collection Bureau there is up to 18% interest.
4. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished by me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier I may have any information needed to determine these benefits or the benefits payable for related services.
5. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
6. I was offered a copy of Idaho Eyelid & Facial Plastic Surgery, PLLC's HIPAA Privacy Act effective date 9/23/2013.

Signed (Patient or parent if minor) _____ Date _____