

BASSIN CENTER — FOR PLASTIC SURGERY —

Dr. Roger Bassin

Patient Demographics

Last Name _____ First Name _____ M.I. _____ Age _____

Address _____ City _____ State _____ Zip _____

Employer (Name) _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

SSN# _____ Birth Date _____ Married ___ Single ___ Divorced ___ Widowed ___

In Case of Emergency Contact _____ Phone _____

Please Print Full Name

Referred by _____

Primary Physician _____

Insurance Information:

The undersigned, understand that I am responsible for all charges for treatment received

Consent for Treatment:

The undersigned authorizes Bassin Center For Plastic Surgery to provide treatment or procedures, which the provider considers necessary and proper in the treatment of the above named patient.

Release of Records:

I hereby authorize the provider to furnish insurance companies with any information concerning my treatment which may be requested, including photocopies of my patient records as necessary for completion of my claim or as may be required by law. I further authorize the provider to furnish information from my patient records pertaining to the treatment as requested by other doctors or medical care facilities for continued care treatment.

Payment agreement:

I, The undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. Patients who are confirmed for office based appointments and "no show" are subject to forfeiture of costs. Patients who have paid in full for surgery and cancel are subject to 50% forfeiture.

Legality:

Any legal dispute that arises with the Bassin Center, the patient will be responsible for legal fees incurred by the Bassin Center

Consultation Fee:

The undersigned understands that there is a \$100.00 non-refundable consultation fee due for all new patients. Administrative Processing Fee: All refunds are subject to an administrative processing fee of 15% I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physician/organization to submit a claim to my health insurance carrier on my behalf.

Signature _____ Date _____