

PLASTIC, RECONSTRUCTIVE & HAND SURGERY

51 Main Street
Hyannis, MA 02601

Diplomate
American Board of Plastic Surgery

PLEASE PRINT: **DATE:** _____

NAME: _____ SEX: MALE _____ FEMALE _____

BIRTHDATE: _____ MARRIED: _____ DIVORCED: _____ SINGLE: _____ WIDOW: _____

MAILING ADDRESS: _____ STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ @ _____ . _____ SOCIAL SECURITY #: _____

ALLERGIES: _____ FAMILY DOCTOR: _____ OTHER REFERRAL: _____

INSURANCE INFORMATION

INSURANCE COMPANY I.D. NUMBER GROUP PLAN

1.) _____

2.) _____

IF THE INSURANCE IS IN SOMEONE ELSE'S NAME, PLEASE FILL IN BELOW:

NAME OF THE INSURED PARTY RELATIONSHIP

IS THIS WORKMAN'S COMPENSATION? YES _____ NO _____

IS THIS AN AUTOMOBILE ACCIDENT? YES _____ NO _____

COMPANY OR ATTORNEY ADDRESS DATE OR INJURY/ACCIDENT

EMPLOYMENT INFORMATION

EMPLOYER ADDRESS PHONE OCCUPATION

SPOUSE/PATENTS EMPLOYER ADDRESS PHONE OCCUPATION

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Marc C. Fater, M.D. for services provided.

SIGNATURE OF PATIENT/PARENT IF MINOR

CAPE COD PLASTIC SURGERY, INC.
51 MAIN STREET
HYANNIS, MASSACHUSETTS 02601
508-771-0290

Marc C. Fater, M.D.F.A.C.S.
American Board of Surgery
American Board of Plastic Surgery

Cosmetic Surgery
Plastic and Reconstructive Surgery
Surgery of the Hand

FINANCIAL RESPONSIBILITY STATEMENT:

I understand that if my insurance company requires a referral, I am responsible for obtaining it. Without said referral, I am financially responsible for all charges incurred. For and in consideration of services rendered, or to be rendered to myself, as a patient of **Cape Cod plastic Surgery, Inc.**, the undersigned agrees to pay **Cape Cod Plastic Surgery, Inc.**, for all charges incurred. Should the account for charges be referred to a collection agency or to an attorney for collection, I shall pay reasonable collection or attorney fees and court costs as collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION:

I authorize direct payment to **Cape Cod Plastic Surgery, Inc.** for these services at a rate not to exceed **Cape Cod Plastic Surgery, Inc.'s** regular charges. It is agreed that the payment of these benefits to **Cape Cod Plastic Surgery, Inc.** shall not discharge my responsibility to pay for charges not covered by my insurance plan. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize **Cape Cod Plastic Surgery, Inc.** to disclose portions of the patients record, including medical records, to any person or corporation or governmental agency which is or may be liable for all or any portion of the **cape Cod plastic Surgery, Inc.** charges. If payment is to be made under Title XVIII of the Social Security Act, I certify that the information given by me in applying for payment is correct and authorize any owner of medical or other information about me to release to the Social Security Administration or its intermediates or carriers any information needed for this or nay related Medicare claim.

WORKMAN'S COMPENSATION:

If my medical problem is work-related, then I am responsible for obtaining a form from my employer specifying **First Report of Accident/Injury**. To change a claim to Workman's Compensation involves extensive paperwork and a reduction of physician reimbursement. Therefore, I will be responsible for any additional fees incurred for this increased paperwork and reduction of reimbursement in I later change my claim to Workman's Compensation.

Patients Signature (parent in minor)

Date

Insured (if other than patient)

Date

Witness

Date