

# PEARL PLASTIC SURGERY CENTER

Samuel N. Pearl, M.D.

How were you referred to our office? \_\_\_\_\_

What type of service or consultation are you interested in? \_\_\_\_\_

Dr./Mr./Mrs./Ms.: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ Soc.Sec. No. \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

May we contact you by phone with reminder calls on office visits, pre-operative instructions, etc.?	Yes	No
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If yes, what telephone number do you wish us to use? _____
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If you are not available, may we leave a message with the person/voicemail answering the phone?	Yes	No
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May we contact you by email with reminder calls, office updates, or requested information?	Yes	No
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Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Person to contact in case of any emergency: \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

## FINANCIAL RESPONSIBILITY- ASSIGNMENT OF BENEFITS

I AUTHORIZE THE PEARL PLASTIC SURGERY CENTER to release any and all medical information to the applicable insurance carrier(s). I authorize payment to be made directly to Pearl Plastic Surgery Center of all benefits payable to me under the terms of my policy for the professional services, laboratory, and facility fees (including laser, instruments, Implants, garment, etc.). It is understood that any payment received above my indebtedness will be refunded to me when my bill is paid in full.

I FURTHER UNDERSTAND that should my Insurance carrier fail to either pay the full amount of the charges, or deny the claim entirely, I am personally responsible for the balance of all charges.

IT IS ALSO UNDERSTOOD that all procedures not covered by insurance (cosmetic) will be my sole responsibility. (This includes all consultations.)

THIS AUTHORIZATION shall remain valid and effective from the date of signing until revoked in writing, and a photocopy of this form shall be deemed as valid as the original.

## RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Privacy Notice for Pearl Plastic Surgery Center.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_