# Wendy R.Gottlieb M.D., P.L.C.

*Plastic and Reconstructive Surgery*

**Please email forms to our secure portal at plasticsoffice@myupdox.com**

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|---|---|---|---|---|---|---|
| **Patient Name** First M.I. Last | | | **Male/Female**? M or F | **Social Security** | | **Date of Birth** |
| **Home Address** | **APT#** | **City** | | **State** | **Zip** | **Home Phone** |
| **Employer** Address | | | | | | **Work Phone** |
| **Occupation** | | **Referred by?** | | | | **Cell Phone** |
| **How did you hear about us?** | | **Physician's Name** | | **Physician's Phone** | | **Marital Status** ___S___M___W___D |
| **Pharmacy Name** | **Pharmacy Phone** | **Pharmacy Address** | | | | |
| **Person to contact in case of Emergency** (Include Relationship) | | | | | | **Telephone** |
| **May we leave a message** (Please circle all that apply) **Home Work Cell Email** | | | **Email address** | | | |
| **May we discuss your medical condition with any member of your family?** (If yes, whom?) | | | **Spouse/Significant Other's Name** | | | |
| **Would you like to join our email list? We will notify you with special discount pricing and future events.** | | | **YES/ NO** | | | |

| **Primary Insurance** Billing Information | **Secondary Insurance** Billing Information |
|---|---|
| Ins. Co. Name: _____ | Ins. Co. Name: _____ |
| Address: _____ | Address: _____ |
| City, State & Zip: _____ | City, State & Zip:_____ |
| I.D. No.: _____ | I.D. No. : _____ |
| Group Name: _____ Group #:_____ | Group Name: _____Group #:_____ |
| Subscriber: _____ | Subscriber: _____ |
| Subscriber's Date of Birth: _____ | Subscriber's Date of Birth: _____ |
| Subscriber's Social Security #:_____ | Subscriber's Social Security #:_____ |

**PAYMENT POLICY**

We are committed to providing you with the best possible care. We will help you receive your maximum allowable insurance benefits; however, we need your assistance. Your insurance contract is between you and your insurance company. We will file a claim with your insurance carrier. You are responsible for paying your bill. Co-pays are due at the time of service. In the event that your account is turned over to a collection agency, you will incur additional fees/costs to the maximum allowable by law. In addition, if we do not participate with your insurance carrier, you may be responsible for a higher proportion of your bill. By signing this form you are acknowledging our policies and agreeing to pay all fees.

**There is a fee of $15.00 - $50.00 for the completion of any forms. Payment is due when the blank forms are given to the office.**

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Wendy R. Gottlieb, M.D., for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance carrier agreements. I understand that I am responsible for any amount not covered by my insurances.

If you provide your email address, we assume you are allowing our practice to correspond with you through email. The email may provide personal health information, cosmetic fee quotes, event invitations, and special pricing details. If you wish to opt out please notify the front desk staff. We would be happy to correspond with you through secure email. We do not provide medical advice via email. If you are having an urgent issue please contact the office.

A copy of the HIPAA privacy notice is available by request.

**Signature of Patient/Guardian**_____ **Date:**_____

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