

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

Plastic and Reconstructive Surgery

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

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:** _____

If filling out electronically, by checking this box you are signifying that your typed name is the equivalent of your signature