

Arrowhead Plastic Surgeons, Inc.

EMERGENCY CONTACT

CONTACT'S NAME:

FIRST

MIDDLE INITIAL

LAST

ADDRESS:

STREET

CITY / STATE

ZIP

HOME PHONE: ()

WORK PHONE: ()

RELATIONSHIP TO PATIENT:

PRIMARY INSURANCE

INSURED PARTY:

DATE OF BIRTH:

RELATIONSHIP TO PATIENT:

EMPLOYER:

INSURANCE TYPE:

IDENTIFICATION NUMBER:

SS#

GROUP NUMBER:

SECONDARY INSURANCE

INSURED PARTY:

DATE OF BIRTH:

RELATIONSHIP TO PATIENT:

EMPLOYER:

INSURANCE TYPE:

IDENTIFICATION NUMBER:

GROUP NUMBER:

CONSENT

I hereby authorize Arrowhead Plastic Surgeons, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician rendering the covered services for the next 12-month period.

I authorize Arrowhead Plastic Surgeons, Inc. to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I understand and agree that I am financially responsible to Arrowhead Plastic Surgeons, Inc. for any balance not covered by the above assignment.

SIGNATURE

DATE