How were you referred to our office?	
Patient Information	
Patient Name:	
(Last)(First)	(MI)State
Address:	Apt:
City:	State:Zip:
Best contact phone number, circle one: Cel	
Cell: Home:	Work:
E-mail:	
	Occupation
Address:	
City:	State:Zip:
Insurance and Policy Holder Informa	<u>ifion</u>
Primary Insurance Company:	
Policy # Group) #
Insurance Company Address:	
City	State Zip code
Insurance Company Phone:	State Zip code Policy Holder Relationship
□ Check box if Policy Holder Information (be	
Policy Holder Information Name:	,
(Last)(First)	(MI)
Date of Birth: / / Social Security:	
City:	Apt: State: Zip:
Best contact phone number for policy holde	er, circle one: Cell, Home, or Work
	Work:
Policy holder e-mail:	
Policy holder employer:	Occupation
Policy holder employer address:	
City:	State: Zip:
Secondary Insurance Company:	
Policy # Group	
Insurance Company Address:	
City	State Zip code Policy Holder/Relationship
Insurance Company Phone:	Policy Holder/Relationship
□ Check box if Secondary Insurance Policy H	Holder Information (below) is same as Primary Insurance
Policy Holder Information: Name:	(111)
(Last) (First)	(MI)
Date of Birth: / / Social Security:	
Address:	Apt:
City:	State: Zip:
Best contact phone number for policy holde	
	Work:
Policy holder e-mail:	
Policy holder employer:	
Policy holder employer address:	
City:	State: Zip:
,	=

Release of Medical Information:			
Who may we share your medical into 1	Relationship:Relationship:		
Pharmacy Information:			
Name:Phone:	City:		
Emergency Contact Information:			
Name of Person to Contact in an Er Relationship to Patient:			
Consent for treatment:			
I voluntarily give my permission to the health care provider(s), associates, and such assistant(s) as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from the physician and associates, or until I withdraw my consent in writing.			
Statement of Financial Responsibility/Assignment of Benefits:			
I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Plastic Surgery Associates. I assign and authorize payments to Plastic Surgery Associates. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.			
Patient or Guardian Signature:	Date:		

3201 S. Austin Ave, Suite 305

Georgetown, TX 78626

Photo Consent

Patient	Age
I authorize Plastic Surgery Associates, and Parties") to take pre-, intra-, and post-oper of my evaluation and treatment.	•
I understand that the photos may be store medical records. As able, patient identifyi	···
I approve the photos to be used for the fo	llowing purposes:
 Clinical documentation Testing and credentialing with the A Surgeons Educational activities directed at positive presentations to medical and non-moderation at local, regional, national Publication in medical journals Marketing purposes such as brochumels 	atients and other physicians nedical organizations onal, or international meetings res, educational pamphlets, and
I understand my clinical care will not be at authorize or not authorize use of the photo purpose.	• •
I hereby release and hold harmless the Au and all claims, demands, damagers or ca with the use of the photographs I have he	uses of action in connection
Patient or Guardian Sianature:	Date: