LauferInstitute
of Plastic Surgery
3129 Alternate 19, Dunedin, FL 34698
Phone (727) 400-4768 *Fax* (727) 408-5197
Erel Laufer, M.D., FACS

Chart# _____
(office use)

Last: _____ First: _____ MI: ___ DOB: _____ Age: ____ Sex: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____ @ _____

Employer: _____ Occupation: _____

Social Security: _____ Driver's License: _____ Marital Status: _____

Spouse or Parent's Name: _____ Phone: _____

Person to Contact in case of emergency: _____ Phone: _____

How did you hear about us? _____

Family Doctor: _____ Phone: _____

RESPONSIBLE PARTY NAME (if other than yourself)

Last: _____ First: _____ MI: ____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Driver's License: _____

Employer: _____ Occupation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Were you involved in an accident? _____ Work Related? _____

State Briefly What Happened: _____

Date of Accident: _____ Verified: _____ Date: _____

Please remember that Insurance is considered a method of reimbursing the patient fees to the doctor and is not substituted for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLING WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

1. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Laufer Institute of Plastic Surgery (Erel Laufer, M.D.,P.A.). This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure the payment. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patient's records.
2. If my account is sent to your attorney, I will be responsible for all the fees associated in the collection process. These fees include attorney costs, interest, process serving fees, as well as the total principal amount due.

Signature: _____ Date: _____