PLASTIC SURGEONS OF LEXINGTON

1401 HARRODSBURG RD.
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LEXINGTON, KY 40504
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ANDREW M. MOORE, M.D.
JOHN MICHAEL MOORE, M.D.
SHERWOOD MOORE, M.D.
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DEAR PATIENT: As part of our service to you, insurance claims will be filed directly to your insurance company or employer. Many claims are submitted electronically (entered directly into the agency's computer) for quicker processing. Assist us by *clearly* and *correctly* completing the following information.

PATIENT INFORMATION:

FIRST NAME			MIDDLE INTIAL	LAST NAME	
PATIENT'S GENDER MALE FEMALE	AGE	BIRTHDATE -- --	SOCIAL SECURITY NO. -- --	MARITAL STATUS SIN MAR SEP DIV WID	EMPLOYMENT FULL PART RETIRED STUDENT

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
( ) --	( ) --	( ) --

IN CASE OF EMERGENCY NOTIFY:	PHONE NUMBER
	( ) --

NAME OF PRIMARY CARE DOCTOR :	NAME OF DOCTOR WHO REFERRED YOU:

DAYTIME PHONE NUMBER OF RESPONSIBLE PARTY:

( ) --

PATIENT'S PREFERRED LANGUAGE	PATIENT'S RACE	PATIENT'S ETHNICITY

COMMUNICATION PREFERENCE: PLEASE CHECK OR PROVIDE INFORMATION

EMAIL:__________ PHONE:__________ MAIL:____

BILL TO:

FIRST NAME			MIDDLE INTIAL	LAST NAME	
SEX MALE FEMALE	AGE	BIRTHDATE -- --	SOCIAL SECURITY NO. -- --	MARITAL STATUS SIN MAR SEP DIV WID	EMPLOYMENT FULL PART RETIRED STUDENT

MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
( ) --	( ) --	( ) --

AUTHORIZATION:

I request payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I consent to have my protected health information released to insurance carriers OR the Centers for Medicare & Medicaid Services and it agents OR the Social Security Administration or its intermediaries OR Any Agency, group or person(s) necessary to secure treatment, payment or business operations by the physician or organization. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. *The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering service as ordered by the physician, including medical or surgical treatment, laboratory procedures, X-ray exams or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and that Plastic Surgeons of Lexington has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of uses and disclosures allowed, as well as other rights I have regarding my protected health information

DATE:________________ SIGNATURE:________________

PATIENT (PARENT/GUARDIAN IF MINOR)