OCALA
PLASTIC SURGERY
& DERMATOLOGY

Board Certified Plastic Surgeons:
James Rogers DMD, MD · Navinderdeep Nijher MD · Jennel Carreras-Montgomery MD
Board Certified Dermatologist: Jessin Blossom MD, FAAD

INSURANCE INFORMATION

PRIMARY INSURANCE | **ID/POLICY #** | **GROUP #**

SUBSCRIBER'S NAME | S.S. # | BIRTH DATE

INSURANCE ADDRESS

SECONDARY / SUPPLEMENTAL INSURANCE | **ID/POLICY #** | **GROUP #**

SUBSCRIBER'S NAME | S.S. # | BIRTH DATE

MANAGED CARE PLAN (HMO) ☐ YES ☐ NO
IF YES, DO YOU HAVE AUTHORIZATION?

PRIMARY PHYSICIAN'S NAME

AUTHORIZATION # | PHONE #

☐ WORKMANS COMPENSATION — WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO — DATE OF INJURY — WORKERS COMPENSATION CLAIM #

☐ ACCIDENT — WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO — DATE OF ACCIDENT — AUTO ACCIDENT CLAIM #

ADJUSTER NAME & PHONE #

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- It is your responsibility to pay any deductible amount, co-insurance, co-pay or any other balance not paid by your insurance.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

I understand that I am responsible for all expenses incurred, including doctor's fees (and Paddock Park Surgery Center, if applicable). I also understand and agree that if this office receives no payment within sixty days, my signature acknowledges that I will be responsible for the entire unpaid balance regardless of the reason for denial. I also understand that I am responsible for any additional charges incurred if my account is turned over to a collection agency for non-payment.

Patient Signature **Date**