Office of Steven Ugras, M.D.
Hand Surgery

PLEASE PRINT CLEARLY – PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I.:_____ Age:_____

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

Birth Date:_____ SS#:_____ E-Mail:_____

Gender:_____ Marital Status:_____ Home Phone: _____
Cell:_____

Emergency Contact Name:_____ Number:_____

Family Dr. Name, Address, & Phone:_____

Referred By (Phone&Address):_____
Employer:_____Work Number:_____ Occupation:_____

PRIMARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____ Effective Date:_____

Insured's Name:_____ Relationship to Patient:_____ Birthdate:_____

Insured's Address:_____City:_____ State:_____ Zip:_____

SECONDARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____ Effective Date:_____

Insured's Name:_____ Relationship to Patient:_____ Birthdate:_____

Insured's Address:_____City:_____ State:_____ Zip:_____

TERTIARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____ Effective Date:_____

Insured's Name:_____ Relationship to Patient:_____ Birthdate:_____

Insured's Address:_____City:_____ State:_____ Zip:_____

If the office of Steven Ugras, M.D. participates in your health insurance, we will bill your carrier for any eligible charges that you incur. We will assist you in obtaining authorization for HMO & Managed Care treatment, but **YOU** are responsible for making sure that the appropriate referrals are acquired and are **up to date** with appropriate number of treatment approved. **You are responsible** for payment of any co-insurance amounts, non-covered charges, and denied claims.

If the office of Steven Ugras, M.D participates does not participate in your health insurance, you are responsible for payment of charges at the time of service. You are responsible for any balance remaining after insurance payment to our office. If my insurance company has not paid a claim you submitted for me within 60 days, payments are my responsibility.

It is your responsibility to notify your insurance company & **obtain pre-authorization**, if any surgery or hospital admission is planned. We will be happy to assist you in determining your likely balance due after expected insurance payment & can help arrange a method of payment. Your health insurance is a contract between you & your insurance company. We cannot accept responsibility for negotiating any type of settlement on a disputed claim if your pre-authorization is not obtained.

I hereby authorize payment from the insurance company to be sent **directly** to **the office of Steven Ugras, M.D** for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for the office of Steven Ugras, M.D. to complete the necessary insurance forms. I give permission to **The office of Steven Ugras, M.D** to appeal any denials or under payment received from my insurance company.

I am aware that the practice of medicine & surgery is not an exact science and acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Dr. Steven Ugras will attempt to improve me, but cannot guarantee to return me to **normal status**.

Signature:_____ Date:_____