Georgia Center
plastic & reconstructive surgery
Joshua R. Groves, M.D.

Patient Information

Patients Name (first)_____ (Mid. Initial)_____ (last)_____

(If Patient is a Minor Child, Please give full name of parent or legal guardian _____)

Address_____

City_____ State_____ Zip_____ County_____

E-Mail address_____ Date of Birth: _____

Home phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Please circle: Male Female Transgender

Please circle: Married Single Divorced Widowed

Race (Please circle): White Black or African American Asian Other: _____

Social Security # _____ Employer _____

Employer's Address _____ Occupation _____

Please tell us the purpose of today's visit. _____

Accident Information: Date of Accident_____ Type of Accident? _____

Work Related?_____ Auto Accident?_____ Assault? _____ Other? _____

How did you hear about us? Please circle one: magazine ad newspaper ad

family or friend internet physician's office yellow pages other: _____

Were you referred to us by another physician? _____ If yes, who?_____

Name of Preferred Pharmacy: _____

Pharmacy Address: _____ Pharmacy Phone # _____

Our office accepts the following forms of payment: Health/Auto/Workers Compensation insurance, cash, personal check, cashier's check, money order, Master Card, Visa, Discover, American Express and CareCredit. Please note that any check returned for non-sufficient funds will be charged an additional fee of $30.

Insurance Information

Insurance Company_____

Name of Insured_____ Insurance ID: _____

Patient's Relationship to Insured (ex: wife, daughter) _____

Insured's Date of Birth_____ Insured's Place of Employment_____

Are you a participant in a managed care (HMO, PPO, etc.) _____

Insurance Information / Assignment of Benefits/Release of Medical Records

Dr. Groves is proud to announce that he is a participating provider for most insurance carriers and is pleased to accept insurance assignment as soon as your exact coverage is verified by our office, however; due to the overwhelming number and type of policy's insuring patient care, we strongly suggest you call the member services number listed on your card to verify we are on your preferred provider list. Please be advised that our office will not enter into a dispute with your insurance company over any claim submitted on your behalf. Insurance will not be filed for cosmetic visits, or visits determined by Dr. Groves to not be medically necessary (example: breast enlargement, liposuction, hair removal, Obagi treatment and/or products).

I hereby instruct my insurance company to pay The Georgia Center for Plastic and Reconstructive Surgery directly.

Patient/Insured Signature: _____ **Date:**_____

Medical Records

In some cases we may be asked by your insurance company to provide medical records including office notes, photographs or other imaging records for the purposes of processing a claim or to obtain prior authorization for surgery. We cannot guarantee the privacy or security of outside email addresses should this occur. By signing below, you give permission to release such records to your insurance company if requested.

Patient/Insured Signature: _____ **Date:**_____

Receipt Of Our Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy visiting our office and requesting a written copy or by visiting our web page at www.GeorgiaPlasticCenter.com.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient/Insured Signature _____ **Date:** _____