Terri L. Hill, M.D., P.A.
Cosmetic and Reconstructive Plastic Surgery

4785 Dorsey Hall Drive – Suite 111
Ellicott City, Maryland 21042

Welcome to our office! We request that NEW PATIENTS complete this form. Thank you!

PATIENT INFORMATION DATE: _____

Name _____ Sex _____ Birth Date (MM/DD/YY) ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is it okay to call you at work? ☐ Yes ☐ No

*May we email you regarding upcoming events, practice news, specials and discounts? ☐ Yes ☐ No

Are there any restrictions for contacting you? ☐ Yes ☐ No If yes, what? _____

Marital Status (M/S/D/W/Sep) _____ Spouse's Name _____ Spouse's Work # _____

Emergency Contact _____ Relationship _____ Phone # _____

Patient Employed By _____ Occupation _____

How did you hear about us? ☐ Friend (Practice patient) ☐ Friend (Non-patient) ☐ Physician

☐ Internet ☐ Facebook ☐ Print Ad ☐ Television/Radio ☐ Yellow Book

☐ Howard County Community Phone Book ☐ Other_____

BILLING ADDRESS (If different)

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Primary Care Physician Name _____ Phone # _____

Is condition related to: Employment ☐ Accident ☐ ? Date of Onset/Injury_____

If Accident, time of accident? _____ State in which accident occurred? _____

*If condition related to accident, please give appropriate liability or worker's comp insurance info.

Contact person and phone number (if applicable) _____

INSURANCE INFORMATION (Primary)

Policy Holder _____ Relation to Patient _____

Policy Holder's Birth Date (MM/DD/YY) ___/___/___

Address (If different) _____

City _____ State _____ Zip _____ Home Phone _____

Employer's Name _____ Occupation _____

Employer's Address _____ Work Phone _____

Company _____ Policy # _____ Group # _____

Phone #_____ Address for claims _____

SECONDARY OR OTHER INSURANCE

Company _____ Policy # _____ Group #_____

Phone #_____ Address for claims _____

(Over)

Please read ALL statements below as they apply to ALL patients!

MEDICARE PATIENTS

Please understand that you, the patient, are financially responsible for all charges whether or not you have medical insurance coverage. If there is a difference between the amount billed and the amount paid by the insurance carrier, the remaining balance is the responsibility of the patient. If you have Medicare as your primary carrier, we will be happy to bill a secondary carrier if provided with such information.

I, _____ hereby authorize Terri L. Hill, M.D., P.A. to apply for benefits on my behalf for covered services rendered. I request payment from Medicare, and/or other applicable insurance carrier(s), be made directly to Terri L. Hill, M.D., P.A. (or in care of Medicare Part B benefits, to myself or the party who accepts assignment). I certify the information I have reported concerning my insurance coverage is correct. Further, I authorize the release of any necessary information, including medical information for this or any related claim, to the above-named company, it's billing and/or collection agent(s) (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Finance Administration), and the insurance carrier(s) as noted above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, in writing, by either myself or the above-named carrier at any time.

_____ _____

Patient's/Authorized Individual's Signature Date

INSURANCE COVERAGE AND PAYMENT RESPONSIBILITY

I, _____understand that my insurance, _____ is not accepted by Terri L. Hill M.D., P.A. and payment is expected in full at the time service is rendered. Although the only insurance provider we participate with is Medicare, we will provide you with the information needed to file for reimbursement. A $35.00 fee will be charged on all returned checks. A $10.00 monthly late fee will be charged for overdue accounts. I agree to be responsible for any and all charges due to the following:

- Procedures deemed not medically necessary
- Procedures which may not be covered under my insurance plan
- Procedures performed when my insurance is not active/in effect at time of visits
- Procedures performed even though the provider does not participate with my insurance plan

_____ _____

Patient's/Authorized Individual's Signature Date

CONSENT FOR TAKING AND USE OF PHOTOGRAPHS

I understand that photographic records are made and kept for medical purposes to monitor procedural progress and for educational and scientific purposes. I consent to their use for such purposes.

_____ _____

Patient's/Authorized Individual's Signature Date