Wesley W. Hall Jr, M.D.
Scott W. Wrye, M.D.
635 Sierra Rose Dr. #A
Reno, NV 89511

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Reno, NV 89523

775-284-8296 Office
775-332-6583 Fax

Patient Personal Information

Date: _____

Patient Name: Last_____ First _____ Middle Initial_____

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

DOB: ____/____/_____ Age: _____ ○ Male ○ Female Marital Status ○ Single ○ Married ○ Other: _____

Home Phone: (_____) _____ Cell Phone: (_____)_____

Email: _____ Social Security: _____ - _____ - _____

Spouse's Name: _____ DOB: ___/_____/____ Social Security: _____ - _____ - _____

Emergency Contact: _____ Relation: _____ Phone: (_____) _____

Work Related Injury: ○ YES ○ NO If Yes, Date of Injury: _____ /_____ / _____

Primary Insurance: _____ ID #: _____ Group #:_____

Subscriber: _____ Subscriber DOB: _____/_____/_____ Relationship to Patient_____

Secondary Insurance: _____ID #: _____ Group #: _____

Subscriber: _____ Subscriber DOB: ____/_____/_____ Relationship to Patient_____

COMPLETE ONLY IF A MINOR

Mothers Name: _____ Social Security: _____ - _____ - _____ DOB: ____/_____/_____

Mothers Address: _____ Phone: (_____)_____

Mothers Employer & Address: _____ Phone: (_____)_____

Fathers Name: _____ Social Security: _____ - _____ - _____ DOB: ____ /_____/____

Fathers Address: _____ Phone: (_____)_____

Fathers Employer & Address: _____ Phone: (_____)_____

PATIENT RESPONSIBILTY

I understand that regardless of valid insurance coverage or any 3rd party liability, I am ultimately responsible for any balance due.

ORIGINIAL ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to providers of services related to this hospitalization/ medical treatment from any hospital/medical insurance benefits, or benefits payable from any other entity payable to me. This authorized payment shall not exceed the balance due to the provider's regular charges for this period of hospitalization/ medical services. I understand that I am financially responsible to the providers for charges not covered by this authorization.

INITIATION OF APPEAL

In the event that insurance benefits are denied due to but not limited to non-medical necessity, out-of-provider network services or unusual and customary rates, I agree that it is my responsibility to contact and appeal to my insurance company, and if necessary, The Insurance Commission for the State of Nevada.

FINANCIAL POLICY

We will bill your insurance although we may not be contracted with them. You are responsible for:

1.) Annual deductibles
2.) Co-Payments
3.) Charges for non-covered or cosmetic services

If HALL & WRYE PLASTIC SURGEONS, LTD has to take legal, adverse action (collections) against your account, you will be responsible for the following:

1.) $25.00 administration fee, regardless of the amount on the outstanding balance.
2.) The collection agency's commission of the 40% of the total balance.
3.) A $25.00 returned check fee.

_____ _____

Patient or Guardian Signature **Date**

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to HALL AND WRYE PLASTIC SURGEONS for any services furnished to me that my party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorized any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries/ carrier or any other insurance company needed for this or a related Medicare/Other Insurance Company claim. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

_____ _____

Patient or Guardian Signature **Date**