JOSEPH F. MAZZA, JR, MD

12640 Creekside Lane ~ Fort Myers, Florida ~ 33919
Phone (239) 482-7676 ~ Fax (239) 482-7604

Date: ______________________________

Name:		**DOB:**	

Primary Insurance

Ins. Company:			
Policy or ID #:		**Group Number:**	
Phone:		**Copay:**	
Address, City, State:		**Zip:**	

Secondary Insurance

Ins. Company:			
Policy or ID #:		**Group Number:**	
Phone:		**Copay:**	
Address, City, State:		**Zip:**	

Responsible Party ***(The subscribers name on the insurance card - If self, leave blank)***

Relationship:			
First Name:		**Last Name:**	
Subscribers DOB:		**Subscribers SSN:**	
Address, City, State, Zip:			
Home Phone:		**Cell Phone:**	
Employer:		**Employer's Phone:**	

Consent for Payment

I hereby authorize payment of medical benefits billed to my insurance to Mazza Plastic Surgery. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Mazza Plastic Surgery does not participate with my insurance. I hereby authorize Mazza Plastic Surgery to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, Mazza Plastic Surgery can refuse to treat me. I understand this authorization can only be revoked in writing, and if I revoke my consent, such revocation will not affect any actions that Mazza Plastic Surgery took before receiving my revocation.

Signature of Patient or Patient's Representative: ____

Printed Name of Patient: ____

Relationship of Representative to Patient: ________________________________ ***Date:*** __________