MORGENSTERN CENTER
for Orbital and Facial Plastic Surgery
123 BLOOMINGDALE AVENUE, WAYNE, PA 19087-4056

Office: (610) 687-8771 Fax: (610) 687-8773 www.MorgensternCenter.com

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, _____

Insured: Name _____ DOB _____ Employer _____

Primary Pharmacy

Name _____

Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Notice

Your insurance company will only pay for services that it determines to be reasonable and necessary. If your insurance company determines that a particular service, although it would be otherwise covered, is "not reasonable or necessary" under their program statndards, they will deny payment for that service.

There is a possibility that your insurance company may consider your procedure/surgery to be cosmetic in nature. Since we cannot ask them in advance whether or not they will cover this service, we must wait until the service is billed. Be assured that we will do our best to provide them with all documentation and test results to prove the medical necessity of your procedure. Unfortunately, this does not always guarantee that they will pay for our services. In such case we must bill you for the procedure.

Also, if your insurance plan has a yearly deductible we advise that you check with your insurance company regarding your balance ahead of time. If you have not met your limit, the deductible fees for services will not be paid for by your insurance company even though it is a covered expense. You are responsible for these fees from the Morgenstern Center.

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Morgenstern to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

I understand that my contract is between Dr. Morgenstern and myself.

Signature _____ **Date** _____