Surgery Associates

Patient Registration Form

Please provide all the requested information to avoid delay in your care.

Patient Information

Date: _____/_____/_____ ☐ New Patient ☐ I have been seen by this office before.

Name: _____ ☐ Male ☐ Female
Last Name *First Name* *MI*

Race: ☐ American Indian or Alaskan Native ☐ African American ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Birth date: _____/____/_____ Age:_____ Social Security Number*: _____-_____-_____
**Required for scheduling and billing insurance*

Home Address: _____
Street *City* *State* *Zip Code*

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (___)_____

Email Address: _____

Employer Name: _____ Occupation: _____

Work Address: _____
Street *City* *State* *Zip Code*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Name of Spouse/Parent: _____
Last Name *First Name* *MI*

Spouse/Parent's Social Security:_____-_____-_____ Birth date: _____/_____/_____
**Required if covered by spouse's or parent's insurance*

Spouse/Parent's Employer: _____ Cell Phone: (____)_____

Occupation: _____ Work Phone: (____)_____

Emergency Contact: _____ Phone: (___)_____ Relationship: _____

Preferred Pharmacy: _____

Insurance Information

Primary Insurance:_____ Subscriber: _____

Insurance I.D.: _____ Group: _____

Claims Address:_____ Phone: (___)_____

Secondary Insurance:_____ Subscriber: _____

Insurance I.D.: _____ Group: _____

Claims Address:_____ Phone: (____)_____

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Referring Physician Information

Referring Doctor:_____ Phone: (___)_____
Other physicians to copy reports to:_____

Assignment of Benefits to Physician

To our NON Medicare patients,

I hereby give authorization for payment of insurance benefits to be made directly to Surgery Associates for services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. This includes Worker's Compensation benefits if the claim is pended or denied as non-work related. I hereby authorize Surgery Associates to release all information necessary to secure payment of benefits. I further agree a photocopy of this agreement shall be valid as the original. This assignment will remain in effect until revoked by me in writing.

Medicare Authorization to Pay Benefits to Physician

To our Medicare patients,

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Surgery Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA 1500 claim form or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services, Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Health Eligibility Certification

Dear Patient/Parent,

Your signature on this form acknowledges that you agree to accept full financial responsibility for all services provided by Surgery Associates if any of the following applies:

- You are determined NOT to be eligible for coverage with your health plan.
- The services provided are NOT covered by your health plan.
- The services have NOT been referred or authorized as required by your health plan (ie, an authorization has not been received by our office.)

I,_____, understand that I am eligible for benefits from_____
Patient Name *Health Plan*

As of_____. I understand that if the above is not accurate, I (or the person financially
Effective Date
responsible for me) will be responsible for all services rendered to me by Surgery Associates. I understand that I am responsible for my co-payment (if applicable) prior to my office consultation or visit **X**_____ and if I do not pay it in advance, I will be charged an additional $25 billing fee. *Please initial*

_____ _____
Signature *Date*