

# Surgical Specialists of St. Joseph, P.C.

Specialists in General and Vascular Surgery

## PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you better, we need the following information.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

If you prefer to be called by a different name, please list here: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F Social Security #: \_\_\_\_\_

Check appropriate box:  Minor  Single  Married  Separated  Divorced  Widowed

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Spouse or Parent's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

This office has my permission to:

- Leave a message on my answering machine
- Leave a message with my family
- Do not** leave any messages

Whom may we thank for referring you? \_\_\_\_\_

### RESPONSIBLE PARTY

Person responsible for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Do you have Medical Insurance?  Yes  No *If yes, fill out below information.*

#### Primary Insurance #1

#### Secondary Insurance #2

Insurance Company Name \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Do you have a copay?  Yes  No **If yes**, what is the amount? \_\_\_\_\_

Do you have a deductible?  Yes  No **If yes**, what is the yearly deductible amount? \_\_\_\_\_ Has this been met? \_\_\_\_\_

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**INSURANCE AND PAYMENT POLICY**

**Payment is due at the time service is rendered.** We accept cash, check, or credit card. We will automatically bill your insurance company, providing we have a signed authorization and release on file from you. A complete list of the **insurance companies with whom we participate** is available from our receptionist. It is **your responsibility** to know what benefits your insurance company will cover. If you should need surgery, we will contact your insurance company for pre-authorization.

**PAYMENTS**

If you have medical insurance, payment due at the time of service will include; office **co-pays** for HMO and PPO companies, any **unmet** calendar year deductibles, **co-payments** that you are responsible for, as well as any **non-covered** services. If you do not have any medical insurance, payment in full is due at the time of service.

Some insurance companies arbitrarily select certain services they will not cover. **You are responsible for full payment of all non-covered services.**

**We must emphasize that our relationship is with you, and not your employer or insurance company.**

I have hereby read and understand the above Insurance and Payment Policy and agree to the contents herein.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INSURANCE ASSIGNMENT AND RELEASE** (Medicare patients must sign if you have a secondary insurance)

I hereby authorize release of information necessary to file a claim with my insurance company on behalf of myself (or my minor child). I assign all benefits to the physician indicated on my (or my minor child's) claims for service rendered that would otherwise be payable to me. In order for the physician indicated to secure payment of benefits, I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me (or my minor child) during the period of such care to third party payors and/or other health practitioners. I understand that I am financially responsible for any balance not covered by my insurance carrier. Photocopies of such information and authorizations shall be considered as valid as the originals.

If this is a workers compensation claim, I understand that if services are rejected by workers compensation as not being work related or in dispute as a work-related injury, that I am financially responsible for these charges.

I authorize the physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

This authorization is in effect until I choose to revoke it.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian** \_\_\_\_\_ **Date**

**MEDICARE AUTHORIZATION**

**NAME OF BENEFICIARY:** \_\_\_\_\_

I request that payment of authorized Medicare benefits be made to me or on my behalf to Surgical Specialists of St. Joseph, P.C. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named physician/supplier any information regarding my Medicare claims under Title XVII of the Social Security Act. This authorization is in effect until I choose to revoke it.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian** \_\_\_\_\_ **Date**

**PARENT/GUARDIAN AUTHORIZATION FOR TREATMENT OF MINOR** (fill out only if registration is for a child)

I authorize treatment of my child, \_\_\_\_\_ by the physicians of Surgical Specialists of St. Joseph, P.C., to conduct such exams and treatments as may be necessary for proper health care. All information on registration and medical history forms concerning the above said minor is correct to the best of my knowledge.

\_\_\_\_\_  
**Signature of Parent /Guardian** *Please print name* **Relationship to Child** \_\_\_\_\_ **Date**