SILLECT
CENTER FOR SURGERY
3545 San Dimas St.
Bakersfield, CA 93301
661-323-1947

Date: _____ **Time In:** _____

Patient Name: _____ ☐F ☐M
Last Middle First

DOB: _____ Age: _____ Social Security: _____

Driver's License: _____ Race: _____ Ethnicity: _____

Cell Phone: _____ Home: _____ Email: _____

Address: _____
City State Zip

Employer: _____ Phone: _____ Occupation:_____

Next of Kin: _____ Phone: _____ Relationship: _____

Best form of communication: ☐Home Phone ☐Mobile Phone ☐Email ☐Mail ☐Other _____

Emergency Contact: _____ Phone:_____ Relationship to Patient:_____

Insurance:

Primary insurance: _____ Secondary insurance: _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Acknowledgement of receipt of privacy notice
I acknowledge that I have access to the Privacy Notice. In order to maintain healthcare costs, copies of the Privacy Notice are distributed in the patient waiting area for my viewing. I may obtain a copy upon request.

Financial Agreement

1. **In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE SURGERY CENTER IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE SURGERY CENTER.** Should the account be referred to an attorney or licensed collection. I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days from date of service) shall bear interest at the legal rate.
2. I hereby authorize direct payment to the surgery center of any insurance benefits otherwise payable to me for this admission at a rate not insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment.
3. A photo static copy of this assignment shall be considered effective and valid as the original.

I understand that the Surgery Center shall have the right at any time to refuse to admit me or to provide medical care or treatment for me.

I certify that I am the patient or am duly authorized by the patient's general agent to execute this document and accept its terms.

I understand that, as a courtesy, the Center will file my primary insurance. After 60 days for the date of surgery, the total balance will be considered due and payable.

Signature: _____ Date: _____ Witness: _____