



Date: _____ Time In: _____

Patient Name: _____ F M
Last Middle First

DOB: _____ Age: _____ Social Security: _____

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

Cell Phone: _____ Home: _____ Email: _____

Address: _____

Employer: _____ Phone: _____ City State Zip
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: _____