Patient Information Form

Who referred you here: _____ Physician ☐ Family/Friend ☐ Other ☐ Pharmacy Name & Location: _____

Patient Information

Name: _____ (Legal Name) **Age** _____
Last First Middle

Patient Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Sex: **F** ☐ **M** ☐ Marital Status: **M** ☐ **S** ☐ **W** ☐ **D** ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email Address: _____

Language: English ☐ Spanish ☐ Japanese ☐ Other ☐ Unavailable ☐ Ethnicity: Non-Hispanic ☐ Hispanic ☐ Declined ☐ Unavailable ☐

Race: African American/Black ☐ American Indian/Alaskan Native ☐ Caucasian/White ☐ Native Hawaiian ☐ Other ☐ Declined ☐ Unavailable ☐

Disabled ☐ Retired ☐ Unemployed ☐ Student ☐ Employed ☐ Employer Name & Address: _____

Preferred Communication: Patient Portal ☐ Mail ☐ Phone (Home) ☐ Phone (Cell) ☐ Phone (Work) ☐ Patient Occupation: _____

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

Parent Information (For Minors Only)

Primary Custodial Parent: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer Name & Address _____

Other Parent: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer Name & Address _____

Guarantor Information

Guarantor Name: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Employer Name & Address _____ Work Phone: _____

Is your visit due to an injury on the job? _____ **Is Workers Compensation Involved?** _____

Insurance Information:

Our goal is to file your insurance correctly; a front and back coy of your current card will help ensure this. If you do not have insurance, please check with the front desk regarding payment options that are available

Primary Insurance – Insured's Name: _____ Insured's Date of Birth: _____

Primary Insured's Social Security #: _____ Policy Holder ID #: _____

Primary Insurance Name: _____ Primary Insured's Employer: _____

Secondary Insurance – Insured's Name: _____ Secondary Insured's Date of Birth: _____

Secondary Insured's Social Security #: _____ Secondary Policy Holder ID #: _____

Secondary Insurance Name: _____ Secondary Insured's Employer: _____

Signature of Patient/Guardian _____ **Date** _____

Revised 02/15/2018

SURGERY ASSOCIATES, P.A.

Patient's Request to Release Information to Contact Person(s)

PATIENT NAME _____ **Chart#** _____

Surgery Associates, P.A. will not discuss your personal health information or billing information with anyone except those allowed under federal and state law without your authorization. Please list the name and relationship of those you authorize us to discuss your personal health information and billing information. By signing below you are authorizing the release of your personal health information and billing information to the person(s) named below. It will be your responsibility to notify us if there are any changes to this form including additions or deletions.

Contact Name	Date of Birth	Relationship	Phone #
Contact Name	Date of Birth	Relationship	Phone #
Contact Name	Date of Birth	Relationship	Phone #
Contact Name	Date of Birth	Relationship	Phone #
Contact Name	Date of Birth	Relationship	Phone #

X _____ _____

Signature of Patient (or personal representative such as parent) Date

Surgery Associates, P.A.

Patient Name _____ **Account #** _____

1. CONSENT FOR TREATMENT: I request and voluntarily consent for Surgery Associates, P.A. or my treating physician(s) to provide medical and surgical services to me, or to a minor for whom I am responsible.

2. RELEASE AND RESPONSIBILITY: I understand and agree that should I leave Surgery Associates, P.A. without the consent of my physician(s) (against medical advise) that Surgery Associates, P.A. or my physician(s) will not be held liable for such action. Therefore, I hereby relieve Surgery Associates, P.A. or my physician(s) of all responsibility of such action.

3. ASSIGNMENT OF BENEFITS: As a patient, I hereby make the assignment of benefits as set forth:

   Medicare and/or Medicaid: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services rendered by Surgery Associates, P.A. or my physician(s) shall be made to Surgery Associates, P.A. or my physician(s), and I specifically assign such benefits to Surgery Associates, P.A. and my physician(s). I hereby certify that all information given by me in connection with applying for benefits under Title XVII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid program and that I may be responsible for the entire charge incurred unless other third party coverage is available. I also understand that all deductibles are due unless they have been met within the period specified by Medicare.

   INSURANCE: I hereby assign to Surgery Associates, P.A. or my treating physician(s) all rights, benefits and interest under any insurance policy, health plan, worker's compensation or other third party payor liable to me, in consideration for services rendered by Surgery Associates, P.A. or my treating physician(s). I hereby authorize payment directly to Surgery Associates, P.A. or my physician(s) by any insurance company for services received by Surgery Associates, P.A. or my treating physician(s).

4. FINANCIAL RESPONSIBILITY AGREEMENT: I understand that I am financially responsible to Surgery Associates, P.A. or my treating Physician(s) for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, co-pays, non-covered charges and other items that are not paid by insurance are due and payable at the time of service based on the best estimates available as determined by Surgery Associates, P.A. or my treating physician(s) and any charges remaining on this account not covered by insurance are payable on demand. If I do not have insurance, I take full responsibility for the payment of all charges incurred on this account. I also agree that in case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by me. I also understand, agree and authorize Surgery Associates, P.A. or my treating physician(s) to verify employment status for the purpose of processing the bill for payment.

5. FINANCIAL RESPONSIBILITY FOR DIVORCED PARENTS: I understand and agree that if I am the parent that brings the child to the office or hospital for treatment by Surgery Associates, P.A. or my treating physician(s), it is my responsibility to pay all charges incurred for services rendered. I further understand that any arrangements made between the two parents concerning payment is the responsibility of the parents not Surgery Associates, P.A. or my treating physician(s).

6. NON-CERTIFICATION OF SERVICES: I hereby agree that as the policyholder/beneficiary of insurance, I am responsible for assuring certification is obtained from the insurance company for the services provided. If certification is not obtained, I further agree that in the event the insurance company deny either or part of the payment on this account, I will pay the account in full upon demand from Surgery Associates, P.A. or my treating physician(s).

7. CONSENT FOR RELEASE OF HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES: I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by Surgery Associates, P.A. or my treating physician(s) for the purpose of billing, claims management, medical data processing, eligibility documentation, reimbursement, certification to any insurance company which is necessary for the billing and payment of this account. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my entire medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any, protected by Federal Confidentiality Rule 42 CFR Park 2, and other common medical records documentation made by the physician, nurse or other ancillary personnel for the entrie time I was treated at Surgery Associates, P.A.

8. CONSENT FOR RELEASE OF HEALTH INFORMATION FOR TREATMENT PURPOSE: I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by Surgery Associates, P.A. or my treating physician(s) for the purpose of medical treatment to other physicians or facilities that are involved in my medical care. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my complete medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any protected by Federal Confidentiality Rule 42 CFR Park 2, and other Common medical records documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated at Surgery Associates, P.A.

9. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received and had an opportunity to ask questions concerning Surgery Associates, P.A.'s Notice of Privacy Practices.

This is to certify that I, the undersigned, being the patient or another person legally authorized to act for the patient, have read paragraphs 1-8 of this document, understand its content, and agree to the terms. I understand and agree that a copy of this authorization is as valid as the original. I understand and authorize the release of my personal health information or billing records by facsimile. I agree and understand that this authorization will remain valid until it is terminated by the patient or another person legally authorized to act for the patient.

Signature of Patient _____ Signature of Guardian _____

Date _____ Relationship to Patient _____ Date _____

Witness to Signature _____ Witness To Signature _____

PRIOR EXPRESS CONSENT FORM **Patient #_____**

I, _____, "Consumer" understand that it is important for Surgery Associates, P.A., David H. Gilliland, M.D., Raymond J. Orgler, Jr., M.D., Newt P. Harrison, Jr., M.D. and R. Stephen McAdory, M.D. "Service Provider" or an Authorized Entity (as defined below) to be able to communicate with me and have current information about me, my address, my phone number(s), and any other information about me that may assist Service Provider or an Authorized Entity in locating me or communicating with me. In consideration of Service Provider or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Consumer expressly consents and agrees to the terms and conditions contained in this Prior Express Consent Form.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider and any related or affiliated health care provider, physician, service provider, independent contractor (including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insurers, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities, and all agents and representatives of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of the previously listed persons/entities, including any collection agency or debt collector retained or hired by any of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of them. The term Authorized Entities shall also include any person or entity conducting business or providing services relating to health care at the same physical location at which the Service Provider or any of the previously listed persons/entities conducts some or all of its business, and any person or entity Consumer is referred to by Service Provider, and any person or entity who provides health care services related to the services provided by Service Provider.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of this Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize any and all of the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any Authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contained herein and on my promise to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

This Consent shall ensure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

Patient Signature _____ Guardian Signature _____

Date_____ Relationship to Patient _____Date _____

Witness to Signature _____ Date_____

My landline telephone number(s):_____

My cell telephone number(s):_____