REGISTRATION

PATIENT INFORMATION

NAME (LAST, FIRST, MI) | BIRTHDATE | AGE | SEX | MRN

ADDRESS | SSN | MARITAL STATUS | PRIMARY INS. COPAY

CITY, STATE, ZIP CODE | CELL PHONE NO. | HOME PHONE NO. | WORK PHONE NO.

EMPLOYER | EMPLOYER TELEPHONE NUMBER | OCCUPATION

ADDRESS | CITY, STATE, ZIP CODE | EMAIL

EMERGENCY CONTACT

NAME (FIRST MI LAST) | RELATIONSHIP | PHONE NO.

PRIMARY INSURANCE

INSURER | INSURED'S NAME (FIRST MI LAST) | PATIENT'S RELATIONSHIP TO INSURED

INSURED'S ID NO. | GROUP NO. | AUTHORIZATION | BIRTHDATE | INSURED'S SSN

SECONDARY INSURANCE

INSURER | INSURED'S NAME (FIRST MI LAST) | PATIENT'S RELATIONSHIP TO INSURED

INSURED'S ID NO. | GROUP NO. | AUTHORIZATION | BIRTHDATE | INSURED'S SSN

RESPONSIBLE PARTY

FULL NAME | GUARANTOR SSN | RELATIONSHIP TO PATIENT

STREET ADDRESS | CITY, STATE, ZIP CODE

MEDICAL INFORMATION

DATE OF SURGERY | TIME | ANESTHESIA TYPE | DIAGNOSIS

SURGEON | ASSISTANT SURGEON

PROCEDURES

Financial:

I hereby certify that the information above regarding my health insurance coverage is true and correct and I understand that failure to provide this information may result in rejection of this claim. Even though insurance may pay for this service,
I understand that frequently insurance only pays part of the charge, or the type of procedure performed is not a covered service including implants, pathology, labs, or other required services.
I understand that proceeds of insurance will be promptly credited to my account when received. Any additional monies will be due and payable in 30 days. I agree that this applies to all procedure/ facility charges.

Assignment of Benefits:

I authorized the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance of all accounts in the event this authorization is insufficient to liquidate this account. I hereby assign and transfer any insurance benefits including Medicare due me for professional surgical services and /or professional anesthesia services to be paid directly to AOS Surgery Center.

Release of Information:

I understand that the financial information herein supplied by me may be provided to other health care providers involved in the performance of patient care at AOS Surgery Center.
I understand that should my account be sent to collection or require litigation to liquidate, I would be responsible for any attorney fees and extra costs incurred. I acknowledge receipt of the Notice of Privacy Practices statement.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the Notice of Privacy Practices. A detailed version of this notice is available upon request.
_____ I do not wish for any information regarding my Personal Health or Medical records to be shared.
_____ I allow for my Personal Health Information or Medical records to be shared with:

_____

I further acknowledge that the information stated above is correct to the best of my knowledge.

_____ NAME OF PERSON COMPLETING FORM | _____ WITNESS | _____ DATE

_____ RESPONSIBLE PARTY | _____ RELATIONSHIP | _____ DATE