

Patient Information

It is this policy of this practice to obtain a copy of every patient's and/or guardian's valid driver's license or photo identification for the purpose of identify verification.

Date: ____ / ____ / ____ Referred By: _____, doctor friend other (circle one)

Patient's Name: _____ Date of Birth: ____ / ____ / ____ Sex: M F (circle one)

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ ext: ____ Other: (____) ____ - ____ cell pager other (circle one)

Street Address: _____ City: _____ State: ____ Zip: _____

Driver's License #: _____ State: ____ SSN: ____ - ____ - ____ Marital Status: M S W D Sep (circle one)

Spouse or Guardian: _____ Contact Phone: (____) ____ - ____ ext: ____

Emergency Contact (other than spouse or guardian): _____ Relation: _____ Phone: (____) ____ - ____

Is this a Motor Vehicle related injury? Y N (circle one) Is this a Work related injury? Y N (circle one)

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

Primary Insured's Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____ Employer: _____

Primary Insured's Street Address and Home Phone (if different from patient):

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ ext: ____ Other: (____) ____ - ____ cell pager other (circle one)

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

Secondary Insured's Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____ Employer: _____

Secondary Insured's Street Address and Home Phone (if different from patient):

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ ext: ____ Other: (____) ____ - ____ cell pager other (circle one)

please continue on reverse side

Patient Authorization

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Arlington Surgical Association, P. A. (A.S.A.) for any charges not covered by my health care benefits. It is my responsibility to notify A.S.A. of any changes in my health care coverage. It is my responsibility, if I have an insurance plan that requires a referral, to obtain the referral from my primary care physician or insurance company and provide A.S.A. with a copy prior to or at the time of my visit. I understand that if I do not provide A.S.A. with a copy my appointment / treatment / procedure will be rescheduled and/or canceled. I am responsible for the entire bill or balance of the bill as determined by A.S.A. or my health insurance carrier if the submitted claim(s) or any part is denied for payment. I understand by signing below I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits: I authorize remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to Arlington Surgical Association, P.A. for all covered medical services and supplies provided to me during all courses of treatment. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Arlington Surgical Association, P.A.

Authorization to Release Information: I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services, my insurance carrier(s) or any entity necessary to determine insurance benefits, disability benefits or the benefits payable for related medical services and/or supplies provided to me by Arlington Surgical Association, P.A. A copy of this authorization will be sent to the Centers for Medicare and Medicaid Services, my insurance carrier(s), my disability carrier or any other medical entity, if requested. The original authorization will be kept on file by Arlington Surgical Association, P.A.

Patient/Patient Representative Signature

Patient Representative Relationship to Patient

_____/_____/_____
Date

A.S.A. Witness Signature

_____/_____/_____
Date