PATIENT INFORMATION

Name (Last) _____ (First) _____ (M.I.) _____

Sex M / F D.O.B. _____/_____/_____ Age _____ Marital Status M S W D Sep SS# _____/_____/_____

Address _____ City _____ State _____

Zip _____ Home/Cell Phone _____ **Email** _____

Employer Name _____ Work Phone _____

Emergency Contact Name _____ Daytime Phone _____

RESPONSIBLE PARTY *(If other than self)*

Name _____ Relationship _____

Address _____ City _____

State _____ Zip _____ Phone _____

INSURANCE INFORMATION

1ST Insurance _____ Policy Holder _____ D.O.B. _____

2nd Insurance _____ Policy Holder _____ D.O.B. _____

Is this related to an ***Auto Accident***? Yes No A ***Work*** injury? Yes No ***Other*** injury or accident? Yes No

Date of injury _____ Type of injury _____

Release of Health Information

I authorize *Surgical Associates of Marquette, PC,* to speak to the following family member(s) or other specified person(s) about my medical care and/or billing information.

YES_____ NO _____ (please initial & signature _____

Name:_____ Relationship to patient_____

Name:_____ Relationship to patient_____

INSURANCE AUTHORIZATION

I authorize *Surgical Associates of Marquette, PC,* to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____

Signature of patient or authorized representative Date

MEDICARE AUTHORIZATION

I CERTIFY that information given by me in applying for payment under Title 18 of the Social Security Act is correct. I authorized any holder of medical or other information about me to the Social Security Administration or its intermediaries or carriers and information needed for this or related Medicare claims. I request payment benefits be made in my behalf. I understand I am responsible for any health insurance and co-insurance.

_____ _____

Signature of patient or authorized representative Date

(Please continue to other side)

NOTICE OF PRIVACY PRATICES ACKNOWLEDGMENT

I, the undersigned, acknowledge that a copy of *"The Notice of Privacy Practices for Surgical Associates of Marquette, PC" and* has been made available to me for my review on this date ***(Copies of "Privacy Policy" are located on tables in waiting room).***

X _____ _____

Signature of patient or authorized representative Date

Surgical Associates of Marquette, P.C.

Financial Policy

Thank you for choosing Surgical Associates of Marquette, P.C. as your healthcare providers. Our billing department staff will work very hard to make sure paperwork is filed accurately and promptly.

WE ACCEPT VISA AND MASTERCARD, DEBIT CARDS, CHECKS & CASH

INSURANCE AND INSURANCE COMPANIES

We bill your insurance company as a courtesy. Our office, as a convenience and service to you, will absorb all costs incurred for billing. Please understand that insurance reimbursement can be a long and difficult process. In fact, insurers will routinely stall, deny, and reduce payments. To prompt faster response/payment from your insurance company, our billing staff has undergone training to maximize your insurance reimbursement. You are required to pay non-covered services, co-pays and master medical services at the time of your visit.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

SELF PAY PATIENTS

If you do not have insurance coverage for an elective procedure you will be asked to sign a payment agreement and make partial payment prior to scheduling your procedure. If you are scheduling a cosmetic procedure you will be asked to sign a payment agreement and make payment in full prior to your surgery being preformed.

MINOR PATIENTS

The adult accompanying a minor child and the parents or guardian of the minor child are responsible for any co-pays and non-covered/master medical services at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless a prior consent for treatment has been signed by the patient's parent or legal guardian.

DIVORCE DECREES

This office is NOT a party to your divorce decree. Adult patients are responsible for their bill for services rendered. The responsibility of minor patients rests with the accompanying adult.

RETURNED CHECKS

If a check is returned by your bank, for any reason, there will be a $25.00 fee assessed, plus you may be required to make future payments by cash, money order, or credit card.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions.

I have read and understand the Financial Policy above. I hereby authorize Surgical Associates of Marquette, P.C. to furnish information to insurance carriers concerning my illness or accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

X _____ _____

Signature of Responsible Party Date