MINIMAL ACCESS SURGERY CLINIC

CHART #: ____________ **Patient Registration** **DATE:** __________________

(PLEASE PRINT CLEARLY!)

PATIENT'S NAME:____
First Name MI Last Name

PATIENT'S SS #: ______________________________

Date of Birth:_______________ __ Male __ Female __Single __Married __Widowed __ Divorced __ Separated

Mailing Address :____

City/State/Zip Code:_______________________________________ Home Phone w/Area Code:__________________

Email address:_______________________________________ Cell Phone w/Area Code:__________________

Patient's Employer:_______________________________________ Work Phone w/AreaCode:__________________

Spouse's Name:_______________________________________ SS #:_______________DOB:___________

Spouse's Employer:_______________________________________ Spouse's Work Phone #:__________________

Responsible Party:_______________________________ Relationship: __Self __Spouse __Parent __Other:________

If patient is a Minor, are parents __Married __Divorced Custodial Parent:______________________________

Custodial Parents' Home Phone w/Area Code:___________________ Work Phone w/Area Code:_______________

Mom's Name:_____________________ Mom's SS#: ___________________ Mom's Date of Birth: ____________

Dad's Name: _____________________ Dad's SS#: ___________________ Dad's Date of Birth: ____________

Referring Physician's Name & Phone Number:____

In case of emergency, contact (not living with you):____

Phone Number w/Area Code:____________________ Relationship to Patient:_______________________

Is this work-related? __Yes __No If yes, date of injury?______________________ Claim #:_______________

How did this injury happen?____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____________________________________ Phone Number:____________________

Primary Insured's Name:_________________________________ Date of Birth:_____________________

Policy #:___________________ Group #:_______________ Relationship:_____________________

Policy Holder's SS#:_____________________

Insurance Company # 2:_____________________________________ Phone Number:____________________

Primary Insured's Name:_________________________________ Date of Birth:_____________________

Policy #:___________________ Group #:_______________ Relationship:_____________________

Policy Holder's SS#:_____________________

- I hereby authorize treatment and payment of medical benefits to Minimal Access Surgery Clinic for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize MASC to release any medical information necessary to complete and process my insurance claims.

I authorize the physicians at Minimal Access Surgery Clinic to treat me and use my personal health information for healthcare operations.

____ ________________

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

MINIMAL ACCESS SURGERY CLINIC
Billing/Authorization Policy

The following sets forth the general billing policy of Minimal Access Surgery Clinic (MASC). Please review this information and sign where indicated.

- I understand that it is my responsibility to provide Minimal Access Surgery Clinic with current, accurate billing information at the time of check in and to notify Minimal Access Surgery Clinic of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- I understand that MASC will verify my insurance eligibility prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to MASC by my insurance carrier.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that MASC will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.
- I request that payment of authorized Medicare benefits be made on my behalf to MASC for any services furnished me by the physician/physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of Minimal Access Surgery Clinic.

____________________________________ ____________________
Legal Signature Date

____
Relationship to Patient

Chart#______________

Birth History

Hospital: ____________________ Obstetrician: ____________________

Type of delivery: _____________ Complication: ____________________

Birth Weight: _________________ Discharge Weight:_________________

Hearing test: Passed ____ Failed ____ Hep. B vaccine at birth: yes____ No____

Type of Feedings: ____

Complications at or after birth: _________________________________

____

Medical and Family History

Sibling Name and Date of Birth

- ____
- ____
- ____
- ____
- ____

Does the patient or any of the patient's relatives have any of the following?
Please indicate relationship to the patient, or if it is the patient.

ADD/ADHD ________________________
Eczema __________________________
Constipation _____________________
Anemia __________________________
Asthma __________________________
Heart Disease ____________________
Seizures ________________________
Birth Defects _____________________
Vision Problems __________________
Speech Problems _________________

Developmental Delay_______________
GE Reflux ________________________
Murmur __________________________
Diabetes _________________________
Allergies _________________________
High Blood Pressure _______________
Cancer ___________________________
Kidney Disease ____________________
Hearing problems __________________

Other____
____
____

Allergies to Medications: _____________________________________

Medications taken daily or as needed: ___________________________
____
____

Surgeries: ____
____

Any special concerns about the patient: ___________________________
____
____
____

I have received a **Notice of Privacy Practices** from Minimal Access Surgery Clinic

______________________________ ______________________
Patient's/Guardian's Signature Date

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(NO MEDICAL OR BILLING INFORMATION WILL BE DISCLOSED TO INDIVIDUALS (*<u>TO INCLUDE SPOUSES AND PARENTS/GUARDIANS)</u>* UNLESS AUTHORIZED/APPROVED BY THE PATIENT IN THE LISTING BELOW)

I hereby authorize Minimal Access Surgery Clinic to disclose my medical and billing information to:

Name: ____________________ Relationship: __________________

Telephone Number: ____________________________

Name: ____________________ Relationship: __________________

Telephone Number: ____________________________

<u>ADDITIONAL COMMENTS</u>

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____
____
____
____
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<u>PLEASE RETURN THIS PAGE TO THE FRONT DESK</u>