

PATIENT REGISTRATION

PLEASE CHECK ONE:

- NEW PATIENT. I am a new patient at this practice.
- CHANGE OF INFORMATION. I have updated information to provide.

PATIENT INFORMATION

Name:			
<i>First</i>	<i>MI</i>	<i>Last</i>	
Mailing Address:			
<i>Street/PO Box</i>		<i>City</i>	<i>State</i>
		<i>Zip Code</i>	
Home Phone#: () -		Work Phone#: () -	
Birth Date: / /		Social Security Number:	
Sex: M F		Employer:	
Marital Status:		Spouse Name:	
Emergency Contact:		Emergency Contact Phone#: () -	

PATIENT INSURANCE INFORMATION

1. My <u>PRIMARY</u> Insurance is with:		Group #:
Policy/Identification#:		
Address to Send Claims:		Phone#:
Policy Holder (If other than self):		Policy Holder's date of Birth:

2. My <u>SECONDARY</u> Insurance is with:		Group #:
Policy/Identification#:		
Address to Send Claims:		Phone#:
Policy Holder (If other than self):		Policy Holder's date of Birth:

3. My <u>TERTIARY (3rd)</u> Insurance is with:		Group #:
Policy/Identification#:		
Address to Send Claims:		Phone#:
Policy Holder (If other than self):		Policy Holder's date of Birth:

Commonwealth Surgery Specialist, PC

TO ALL PATIENTS:

We ask that all patients pay their office visits at the time of service, unless you have prior arrangements made through a payment plan agreement or we participate with your insurance plan.

RETURNED CHECK FEE

I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original sum, I am responsible and agree to pay a \$35 returned check fee. A copy of this agreement may be used in place of an original.

ASSIGNMENT OF BENEFITS

I certify that the insurance information provided with regard to my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to Commonwealth Surgery Specialist, PC.

MEDICARE PATIENTS:

I authorize the holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information for all Medicare claims. I assign the benefits payable for covered services to Commonwealth Surgery Specialist, PC. A copy of this authorization may be used in place of an original.

GUARANTEE OF PAYMENT

I understand and agree that I am responsible for payment of all professional services rendered now and in the future by this practice. If I am insured and this practice is a participating provider with my insurance, I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original.

COLLECTION FEES

If I do not pay all balances owed by me in a timely manner (within 30 days), the undersigned hereby agrees to pay 18% interest per annum on said balances to accrue from the date professional services were originally rendered; plus attorneys fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary.

In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPAA" regulations. A copy of this agreement may be used in place of an original.

Signature of Patient or Responsible Party

Date

PRINT NAME

Relationship (If Responsible Party)