

Premiere Surgical Specialists

Name _____
Last First Middle
Date of Birth _____ Age _____ Social Security # _____ - _____ - _____ Sex: M F Marital Status: M S D W

Mailing Address _____
Street Apt# City State Zip

Physical Address _____
(if different) Street Apt# City State Zip

Patient Employer _____ Occupation _____ Work Number _____ ext _____

Email _____ HomePhone _____ Cell _____

May we leave a message at your home/work pertaining to your healthcare? _____ YES _____ NO

Emergency Contact **NOT** living with you _____ Phone Number _____

To whom may we release information regarding your healthcare?
***PLEASE BE ADVISED: INFORMATION WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN CONSENT!**

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

Is this a work-related or auto-related injury? * _____ Date of injury _____
***If Yes, ask to talk to our billing department**

Primary Insurance Company _____ Employer Name _____

Subscriber's Name _____ Group or Policy # _____

If the insured is someone other than the patient, please fill out the following:

Relationship _____ Date of Birth _____ Social Security # _____ - _____ - _____

Secondary Insurance Company _____ Employer Name _____

Subscriber's Name _____ Group or Policy# _____

Relationship _____ Date of Birth _____ Social Security # _____ - _____ - _____

Insurance Authorization And Assignment

I hereby authorize Premiere Surgical Specialists to furnish information to insurance carriers concerning my illness and treatment and I hereby assign, transfer and set over to Premiere Surgical Specialists all of my rights, title, and interest to my medical reimbursement benefits under my current policy. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE: _____ DATE: _____

Premiere Surgical Specialists

Financial Policies, Authorization and Release Form

Effective February 13, 2003

Updated July 23, 2010

At Premiere Surgical Specialists, our goal is to provide the highest quality medical services to our patients at a reasonable cost.

Patient Responsibility

Full payment is required at the time of service from all patients who have not met their deductible or do not have insurance coverage.

Insured Patients

Patients with health insurance are required to pay all co-pays and co-insurance amounts at the time of service. Be prepared to present your insurance card at each visit. Your insurance policy is a contract between you and your insurance carrier and you are responsible for understanding your coverage, authorization requirements, deductible and co-pay policy. If your insurance company is contracted with Premiere Surgical Specialists, we will bill them for you and make every effort to ensure that claims are promptly and correctly processed. If you are out of network, we will bill your insurance company and make every effort to work with them. **Ultimately, all services provided are the financial responsibility of the patient.**

Occasionally, due to factors beyond our control, an insurance company will not reimburse Premiere Surgical Specialists within 90 days. If payment has not been received from your insurance company within 90 days, then Premiere Surgical Specialists may request that you pay the unpaid balance. Interest is charged at 1.5% monthly if not paid within 30 days. A collection fee of \$100.00 will be added to any balance that is turned over to the collection agency.

Uninsured Patients

Uninsured patients are expected to pay for services in full at the time of service unless other arrangements have been made. Payment plans will not be extended to patients who have failed to make timely payments in the past. New patients are required to pay \$200.00 for their first visit and \$100.00 for each subsequent visit. Payments for surgery are negotiated directly with the billing department. Financial agreements are required.

Request for Additional Form Completion

There will be a \$20.00 charge for special forms to be completed (beyond those used in normal medical reporting). Typical examples are Family Medical Leave Act (FMLA), Disability forms, and Cancer Policies. Please allow up to 2 weeks to complete forms.

Medicare

We are currently accepting assignment on Medicare. If you provide us with complete billing information, we will bill Medicare for you. If you have a secondary insurance we will also bill them. You will receive a statement after both insurances have paid if you have a balance due. If you DO NOT have a secondary insurance, you will be responsible for your 20% co-insurance at the time of the visit. We do not bill tertiary insurances.

Returned Checks

Checks returned for insufficient funds will be subject to a \$45.00 service fee.

Consent to Premiere Surgical Specialists Policy

I understand the above stated Premiere Surgical Specialists financial policies and agree to pay all fees and charges for the patient named below. Charges shown on statements are considered to be correct unless notification is received in writing 30 days of statement date. I agree to pay all charges within 30 days of statement date.

I have read and understand these policies.

Name of Patient or Legally Responsible Person (PRINT)

Signature of Patient or Legally Responsible Person

Patient name (if different)