Patient Name: (First)_____(Last)_____

Date of Birth: ____/____/____ Age: ____ Sex: M / F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address_____ City: _____State: _____ Zip: _____

Best contact Ph#:(____) _____ Alternative Ph#: (_____) _____

Email: _____

Ethnicity (circle one): Hispanic/Latino Caucasian African-American Asian/Pacific Islander Native American Other

Emergency Contact: _____ Emergency Phone#: (____) _____

MEDICAL INSURANCE INFORMATION: ***We will make copies of your insurance cards please have available***

***** Please note that you will be billed separately for services provided by your surgeon and /or Anesthesiologist. ****

Acknowledgement of Review of Notice of Privacy Practices:
I have been given the opportunity to review the Notice of Privacy Practices (HIPAA), which describes how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I ask for one.

SIGNATURE: _____**DATE**: _____

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare benefits be made on my behalf to Falconhead Surgery Center, for services furnished to me by Falconhead Surgery Center. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a secondary insurance is listed, my signature authorizes releasing the information to the insurer or agency shown. Falconhead Surgery Center accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. I understand that if a Medigap policy or other health insurance is indicated, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Falconhead Surgery Center, if possible or otherwise to me.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Falconhead Surgery Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Falconhead Surgery Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, liable to the patient, is hereby assigned to Falconhead Surgery Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Falconhead Surgery Center. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the patient's bill.

_____ _____

PATIENT SIGNATURE **DATE**