

NEW Surgical Associates Patient Registration**Date:** _____

Full Legal Name: _____ **Nickname:** _____
 SSN _____ Male Female Birthdate _____ Home # (____) _____
 Check appropriate box: Minor Single Married Separated Divorced Widowed
 Address _____ City _____ State _____ Zip _____
 Employer _____ Work # (____) _____

Person to contact in case of an emergency: _____ Phone (____) _____
Who may authorize medical treatment for the patient?: Self Parent Legal Guardian
 Name of Legal Guardian: _____ Phone (____) _____

If patient is a child:
 Father _____ DOB _____ Mother _____ DOB _____
 Employer _____ Employer _____
 Work # (____) _____ SSN _____ Work # (____) _____ SSN _____

If patient is a college student, school name: _____ City _____ State _____

If married: Spouse's name _____ DOB _____ SSN _____
 Spouse's Employer _____ Work # (____) _____

Insurance: Name of person who carries insurance in family. _____
 Insured's relationship to patient _____ SSN _____ Birthdate _____
 Insurance company _____ Policy # _____ Group # _____
Do you have any additional insurance?: Yes No If yes, complete the following:
 Name of person who carries the additional insurance _____
 Relationship to patient _____ SSN _____ Birthdate _____
 Insurance company _____ Policy # _____ Group # _____

Consent to Allow Access to Protected Health Information/Contact Permission: Please Answer ALL Questions
 If we need to contact you for matters including test results, appointment reminders, payment issues, coverage of services and benefit determination, we will attempt to reach you by the method you specify. How may we contact you?
By phone: Yes No (work #): _____ **By mail:** Yes No Address, if different. _____
 (home #): _____
 (cell #): _____
 May we identify ourselves as being from your doctor's office? [At home? Yes No] [At work? Yes No]
 May we leave a voicemail or answering machine message? [At home? Yes No] [At work? Yes No]
 May we leave a message with a family member or representative? Yes No If yes, please identify in the next section.

Consent to Access of Protected Health Information: The following are family members or representatives to whom we may disclose your protected health information, such as, but not limited to, test results, appointment reminders, payment issues, benefit determination, and coverage of services. Indicate any restrictions on the type of disclosures to be made to these representatives:
 Name: _____ Phone #: _____ Relationship: _____
 Any restrictions? _____
 Name: _____ Phone #: _____ Relationship: _____
 Any restrictions? _____

Consent to Allow Access to Protected Health Information: I consent for NEW Surgical Associates to contact me in the manner described and to disclose my protected health information to the representatives identified. I may revoke consent at anytime by giving written notice. **Initials:** _____

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of NEW Surgical Associates' Notice of Privacy Practices, which describes how NEW Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure, and rights I may have regarding my protected health information. **Initials:** _____

Billing Insurance: I understand my insurance is billed as a courtesy, and I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections on any amount owed on this or subsequent visits, I agree to pay for all expenses, including reasonable attorney fees. I authorize the release of information concerning my/my child's health care, advice & treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of surgical or medical benefits to NEW Surgical Associates. **Initials:** _____

Consent to Evaluation and Treatment: I agree and give my consent for NEW Surgical Associates to furnish medical care and treatment considered necessary and proper in diagnosing or treating my medical condition. This includes but is not limited to examination, diagnostics, photographs and requests for medical record information.

Signature of Patient or Representative: _____ **Date:** _____
Patient Representative Relationship: _____