

NEW Surgical Associates Patient Registration

Date: _____

Full <u>Legal</u> 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 _____		DOB _____	
Employer _____		Employer _____	
Work # (____) _____		SSN _____	Work # (____) _____
SSN _____		City _____	
State _____		State _____	
If patient is a college student, school name: _____			
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 <u>ALL</u> 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 <u>whether or not</u> 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: _____			
Photocopy of this authorization is as valid as the original.			
Signature of Patient or Representative: _____			Date: _____
Patient Representative Relationship: _____			