South Shore Surgical

PATIENT INFORMATION	**PLEASE COMPLETE ALL WHITE AREAS (PLEASE PRINT)**						
	TODAYS DATE:			REFERRING DOCTOR:			
	LAST NAME:			FIRST NAME & INITIAL:			
	SS#:	SEX: M / F		DATE OF BIRTH:		Race:	
	Ethnicity:	MARTIAL STATUS: MINOR / SINGLE / MARRIED / WIDOW / SEPARATED /DIVORCED					
	ADDRESS LINE 1:						
	ADDRESS LINE 2:						
	CITY:			STATE:		ZIP:	
	HOME PHONE:	WORK PHONE:		CELL PHONE:		EMAIL ADDRESS:	
	EMPLOYER:			EMPLOYER'S ADDRESS:			
GUARANTOR	RESP PARTY LAST NAME:	FIRST NAME & INITIAL:		RELATIONSHIP			
	ADDRESS:						
	CITY:	STATE:		ZIP:			
	SOCIAL SECURITY #:	SEX: MALE / FEMALE		DATE OF BIRTH:			
	RESP PARTY EMPLOYER:	EMPLOYER PHONE:		EXT:			
	EMPLOYER ADDRESS:						
	HOME PHONE:	WORK PHONE:		CELL PHONE:			
PRIMARY INSURANCE	POLICYHOLDER LAST NAME:	FIRST NAME & INITIAL:		RELATIONSHIP:			
	POLICYHOLDER SS#:	SEX: MALE / FEMALE		POLICYHOLDER DATE OF BIRTH:			
	EMPLOYER:	EMPLOYER PHONE:		EXT:			
	EMPLOYER ADDRESS:						
SECONDARY INSURANCE	POLICYHOLDER LAST NAME:	FIRST NAME & INITIAL:		RELATIONSHIP:			
	POLICYHOLDER SS#:	SEX: MALE / FEMALE		POLICYHOLDER DATE OF BIRTH:			
	EMPLOYER:	EMPLOYER PHONE:		EXT:			
	EMPLOYER ADDRESS:						
THIRD INSURANCE	POLICYHOLDER LAST NAME:	FIRST NAME & INITIAL:		RELATIONSHIP:			
	POLICYHOLDER SS#:	SEX: MALE / FEMALE		POLICYHOLDER DATE OF BIRTH:			
	EMPLOYER:	EMPLOYER PHONE:		EXT:			
	EMPLOYER ADDRESS:						
EMERGENCY CONTACT INFO	NEAREST RELATIVE OR FRIEND:			RELATIONSHIP:			
	ADDRESS:						
	HOME PHONE:	WORK PHONE:		CELL PHONE:			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

South Shore Surgical

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis – I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is out policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments – I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

_____ _____

Patient Signature **Responsible Party Signature**

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

DATE_____ **INITIAL**_____

I give consent & authorization for the medical, or billing staff of my physicians office to release information regarding my medical care to:

_____ _____

Name/Relationship **Name/Relationship**

I understand I may revoke this privilege at any time by submitting my request in writing to this office.

PATIENT SIGNATURE_____ **DATE**_____

AUTHORIZATION TO REQUEST SERVICE OR TREATMENT

I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent that action has already been taken in reliance on the consent.

Name_____ **Relationship**_____

Name_____ **Relationship**_____

Name_____ **Relationship**_____

Parent/Guardian Signature_____ **DATE**_____