Medical and Surgical Associates, 1930 Tamarack Road, Newark OH 43055

PATIENT REGISTRATION

Patient name_____ Social Security #_____

Male_____ Female_____ Birth date_____ Age_____ Marital Status: S M D W

Mailing address_____

City_____ State_____ Zip_____

Home phone_____ Cell phone_____ Work phone_____

Employer name_____ Driver's License #_____

Email address_____ Would you like to be contacted by email? Yes No

May we leave a message on your machine/voicemail? Yes No May we leave a message with other residents? Yes No

Who may we speak to regarding your medical concerns?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

May we contact this person whenever needed? Yes No (Only for emergency)

FOR MINORS ONLY: Child lives with Both parents_____ Mother_____ Father_____

****

INSURANCE INFORMATION: (Please complete entirely, even if information is the same as above)

Primary Insurance Company_____
Policy/ID#_____
Group #_____
Policyholder's name_____
Policyholder's SS#_____
Policyholder's DOB_____
Employer name_____
Relationship to patient_____

Secondary Insurance Company_____
Policy/ID#_____
Group #_____
Policyholder's name_____
Policyholder's SS#_____
Policyholder's DOB_____
Employer name_____
Relationship to patient_____

* We participate in one or more Health Information Exchanges. Your Healthcare providers can use this network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your Health Information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying Medical and Surgical Associates Staff or the office Administrator.

Signature of Patient or Guardian_____ Date_____

Please read the following authorization and sign below:
I hereby authorize Medical and Surgical Associates, Inc. and/or any of its representatives to disclose medical or other information obtained in the course of my diagnosis and treatment to any government and/or third party (insurance) payer, or any other entity required by law. I permit a copy of this authorization to be used in place of the original, and request payment of any insurance benefits to Medical and Surgical Associates, Inc. or myself. I further authorize the disclosure of my diagnosis and treatment records, including the charges for the same to any billing service, attorney, or debt collection agency selected by Medical and Surgical Associates, Inc. Said disclosure shall be solely for the collection of charges incurred for treatment provided by Medical and Surgical Associates, Inc. to me and/or my spouse and children. I will notify you of any changes made in my health status or insurance information.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware I may be responsible for all charges that are incurred.

Signature of Patient or Guardian_____ Date_____

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your healthcare information.

I hereby give my consent to Medical and Surgical Associates, Inc. to use and disclose my protected health information for the purpose of treatment, payment and operations of my healthcare at this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the state or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other healthcare professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: have had a chance to review the Privacy Practice Notice as part of this registration process. Understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Revocation: I hereby revoke the consent given above:

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

PATIENT FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. To avoid any questions or problems, we need your assistance and understanding of our financial policy.

1. Alt co-pays are due at the time of service. There is a $5.00 fee for any co-pay not pain on the date the services are provided. Even if you have a secondary insurance that picks up your co-pay, you are responsible for paying the co-pay. We will abide by the contract we have with your primary insurance Company.
2. There is a $50.00 fee for any appointment that is not cancelled 24 hours before your scheduled appointment time. Three consecutive "NO SHOW" appointments will be grounds for dismissal from the practice.
3. Insurance is a contract between you and your insurance company, we will file your insurance claims as a courtesy to you. You agree to pay any portion of the charges not covered by insurance. We will file your insurance claims on time. If no payment is made, the balance is your responsibility. We emphasize that as a medical provider, our relationship is with YOU and NOT your insurance company. We cannot be responsible for any loss of benefits. It is YOUR responsibility to know your policy.
4. Not all services are covered benefits in all insurance contracts. Some insurance companies select certain services they will not cover and regardless of our participation with a plan, payment for any non-covered services will be the patient's responsibility.
5. In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges or co-pays. It is the authorizing parent's responsibility to collect from the other parent if necessary.
6. There is a $40.00 fee for any returned check. Payment will need to be made by cash, credit card, or cashier's check within 14 days for the amount due, and the returned check fee.
7. Accounts over 60 days old are subject to a billing fee.
8. Accounts over 90 days old are subject to a $5.00 delinquent fee. Balances will need to be paid in full at this time to avoid dismissal from the practice and the account being sent over to collections.
9. Accounts over 120 days old or accounts for whatever reason are dismissed from the practice are subject to a $15.00 dismissal fee.
10. Accounts that are sent to collections are subject to the collection agency's fees that are charged to Medical and Surgical Associates, which is usually 30% of the balance sent to collections. The balance includes any interest added, delinquent and dismissal fees, there is a $10.00 fee for any records transferred to another physician. The fee increased to $25.00 if you have an unpaid balance at the time of transfer. Once your records have been transferred, no further appointments will be made with our office.
11. There may be a $20.00 fee for any medication prior authorization your insurance requires.
12. There may be a charge for forms filled out by a physician,

Signature of Patient or Guardian _____ Date _____