

Consultants in General Surgery, S.C.

Patient Information

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ E-MAIL ADDRESS: _____

SOCIAL SECURITY NO: ____ / ____ / ____ BIRTHDATE ____ / ____ / ____ MARITAL STATUS: ____

BILLING INFORMATION (For person who is responsible for the bill, if not same as above)

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: _____

WORK PHONE: _____ SOCIAL SECURITY NO: ____ / ____ / ____ DOB ____ / ____ / ____

INSURANCE CARRIER: _____ ID _____

GROUP NO. _____ CO-PAY _____ DEDUCTIBLE _____

PLEASE READ CAREFULLY:

Collection Policy: Because of skyrocketing increases in overhead and lower reimbursement, we have been forced to adopt a collections policy, which is outlined in a separate handout. In summary, if you do not have insurance, we require payment for the office visit the day of service. If you do have insurance, Co-payments must be made prior to seeing a physician. We also will ask for a payment of the estimated patient charges, prior to surgery.

I hereby authorize Consultants in General Surgery, S.C., Drs, Haggerty, and Loris to render medical services to me.

Signed _____ date _____

Insurance Information: If you are covered by medical insurance please provide the receptionist with your insurance card so that she may photocopy it. For your convenience, our office will submit a claim form to your insurance company each time a charge is posted to your account. Please read and sign below.

I hereby authorize Consultants in General Surgery, S.C. to release to my insurance company any information acquired in the course of my examination and treatment. I hereby authorize benefits to be paid directly to them but understand that payment for services rendered is ultimately my responsibility.

Signed _____ date _____

Privacy Policy: I have received a copy of the practice privacy notice on the date indicated next to my signature.

Signed _____ date _____