



PATIENT INFORMATION SHEET (please print)

Name _____ Date of Birth _____

First Middle Last Gender: M or F

Address _____

Street Apt# City State Zip

Social Security # _ _ - _ - _ _ _ Marital Status: M S W D

Responsible Party: Patient Spouse Parent Other _____

Home Phone Number _____ Cell Phone Number _____

Primary Care Physician _____ PCP Phone Number _____

Who referred you to our office? _____

Doctor's Name Phone Number

Emergency Contact Name _____ Phone Number _____

PLEASE FILL- IN INSURANCE INFORMATION COMPLETELY

Insurance Company _____ Policy Holder Name _____

ID Number _____ Group Number _____ Relationship to Patient _____

Social Security Number of Policy Holder _____

Secondary Insurance _____ ID Number _____ Group # _____

Social Security Number of Policy Holder _____

Tertiary Insurance _____ ID Number _____ Group# _____

Social Security Number of Policy Holder _____

Current Medications:

Are you allergic to any Medications?

Yes

No

Please list the medications that you are allergic to:

Height: _____

Weight: _____

DO YOU CURRENTLY HAVE A LIVING WILL? Y or N IF NO, WOULD YOU LIKE INFORMATION ON ONE? Y or N

I AUTHORIZE PRECISION SURGERY TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY THAT ACCEPTS ASSIGNMENT FOR THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PRECISION SURGERY FOR SERVICES RENDERED AND REALIZE THAT I AM FINANCIALLY RESPONSIBLE FOR THE NON- COVERED SERVICES.

SIGNED _____

DATE _____

CONSENT FOR USE OR DISCLOSURE OF INFORMATION FOR PURPOSES REQUESTED BY PHYSICIAN'S OFFICE

I HEREBY PERMIT PRECISION SURGERY TO USE MY HEALTH INFORMATION, AND/OR TO DISCLOSE MY HEALTH INFORMATION TO ANY THIRD PARTY PAYOR, OR TO ANY PARTY INVOLVED IN MY HEALTH CARE.

I UNDERSTAND THAT THERE IS A NOTICE OF PRIVACY PRACTICES POSTED IN THE PRACTICE RECEPTION AREA AVAILABLE FOR ME TO READ.

THIS CONSENT SHALL BE IN FULL FORCE AS LONG AS I AM A PATIENT AT THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME BY SENDING SUCH WRITTEN NOTIFICATION TO MY PHYSICIAN AT THIS PRACTICE.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO:

- INSPECT OR COPY THE PROTECT HEALTH INFORMATION TO BE USED OR DISCLOSED AS PERMITTED UNDER FEDERAL LAW (OR STATE LAW TO THE EXTENT THE STATE LAW PROVIDES GREATER ACCESS RIGHTS).
- REFUSE TO SIGN THIS CONSENT.

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

DATE



FINANCIAL AGREEMENT

PAYMENT IS DUE AT THE TIME OF YOUR MEDICAL SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE PRACTICE ADMINISTRATOR.

AS A COURTESY WE WILL BILL MOST MEDICAL INSURANCE PLANS. HOWEVER, AS THE PATIENT, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR BENEFIT PLAN (I.E. MAXIMUMS, BENEFIT EXCLUSION, LIMITATION PLAN, DEDUCTIBLES, CO- INSURANCE, PRE- EXISTING, ETC.) PLEASE BE ADVISED WE WILL ESTIMATE YOUR MEDICAL INSURANCE BENEFIT WHEN POSSIBLE. YOU WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY YOUR INSURANCE.

_____ (INITIALS)

THE STAFF AT PRECISION SURGERY DOES THEIR BEST TO MAKE SURE THAT IF YOU REQUIRE A REFERRAL OR PRIOR AUTHORIZATION FROM YOUR INSURANCE COMPANY THAT WE NOTIFY YOU. HOWEVER, AS THE PATIENT, IT IS YOUR RESPONSIBILITY TO PROVIDE A CURRENT REFERRAL OR PRIOR AUTHORIZATION TO OUR OFFICE AT THE TIME OF SERVICE TO PREVENT FROM BEING BILLED FOR THE SERVICES.

_____ (INITIALS)

WE RESERVE TIME FOR EACH PATIENT. THERE WILL BE A FEE OF \$75.00 ADDED TO YOUR ACCOUNT IF YOU MISS YOUR APPOINTMENT. THERE WILL ALSO BE A FEE OF \$350.00 ADDED TO YOUR ACCOUNT FOR A MISSED OPERATIVE APPOINTMENT.

_____ (INITIALS)

ALL PATIENT PORTIONS ARE DUE UPON SERVICES RENDERED. IN THE CASE WHERE WE ARE BILLING YOUR INSURANCE, WE MAY SEND YOU A STATEMENT FOR THE REMAINING PORTION WHICH IS DUE UPON RECEIPT.

_____ (INITIALS)

IN THE EVENT THAT YOUR ACCOUNT IS SENT TO COLLECTIONS, A 25% SURCHARGE WILL BE ADDED TO THE BALANCE.

_____ (INITIALS)

PATIENT/GUARDIAN SIGNATURE

DATE