

SURGICAL ASSOCIATES OF VENICE & ENGLEWOOD

Please read and complete the entire form.

Last Name _____ First _____ MI _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Northern Address _____ City _____ State _____ Zip _____

Home phone # _____ Cell # _____ Northern Ph # _____

Circle which phone number should be your PRIMARY contact number>>> Home Cell Work

Employer _____ Employer Phone # _____

Email Address _____ May we email regarding cosmetic services we offer? Yes No

Primary Insurance Co: _____ Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance Co: _____ Policy Holder: _____ Policy Holder DOB: _____

SS# Primary Policy Holder: _____ SS# Secondary Policy Holder: _____

Emergency Contact: _____ Telephone: _____

Authorization for Direct Payment & Release of Information via Auto-Fax

I authorize release of information to my insurance companies, and any holder of Medicare and/or other insurance companies to support reimbursement for services rendered at Surgical Associates of Venice & Englewood. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the physicians or facility furnishing the services. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies. I authorize Surgical Associates of Venice & Englewood to release information from my medical record to my referring physician and/or primary care physician for the purpose of continued care.

Patient Signature *Date*

Financial Agreement

I understand that I am fully responsible, upon receipt of services or billing invoice, for any charges incurred by me for professional services rendered by the physicians at Surgical Associates of Venice & Englewood. I understand that I may be required to make a payment at the time of any visit, if an insurance co-payment or deductible payment is required. I will be required to make payment on any past due balances on my account. I understand that if Surgical Associates of Venice & Englewood should file a claim with my medical insurance and/or third party representative, it is for my convenience and does not constitute any guarantee of payment by insurance or representative. If care is required and my insurance plan or contract determines the treatment is a non-covered service, and if the plan refuses payment to the provider, I understand I am responsible for full payment of services prior to, or at, the time of services rendered. I understand that, should the charges incurred be the result of an injury involving a third party and I have involved an attorney for purposes of a liability claim against the third party, I am responsible for all charges at the time services are rendered and not at the time of any liability settlement.

Patient Signature *Date*

Acknowledgement

I understand and have been offered or received a copy of the Notice of Privacy Practices provided by Surgical Associates of Venice & Englewood.

Patient Signature *Date*