PATIENT INFORMATION SHEET

(Please Print)

Name: ____ **Date of Birth:** _____________________________

First **Middle** **Last** **Gender:** **M** **or** **F**

Address: ____

Street **Apt#** **City** **State** **Zip**

Race: ____________________ **Ethnicity:** ___________________ **Language:** __________________

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

Home Phone Number: ______________________________ **Cell Phone Number:** ______________________________

Email Address: ____

Primary Care Physician: ____________________________ **PCP Phone Number:** ______________________________

Who referred you to our office? ____

Doctor's Name **Phone Number**

Emergency Contact: _____________________________________**Phone Number:** ___________________________

Relationship to Patient: ____

Name of Responsible Party: __________________________ **Relationship to Patient:** ____________________________

Address: ______________________________________ **Phone Number:** _________________________________

PLEASE FILL- IN INSURANCE INFORMATION COMPLETELY

PRIMARY INSURANCE: __________________________ **Policy Holder Name:** _____________________________

ID #: ______________________________ **Group #:** _______________ **Relationship to Patient:** ________________

Social Security Number of Policy Holder: _______________________

SECUNDARY INSURANCE: ________________________ **Policy Holder Name:** ____________________________

ID #: ______________________________**Group #:** ________________**Relationship to Patient:** _________________

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 and your reaction to them:

Medication:	**Reaction:**
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

Height: ______________________________ Weight: ________________________

Blood Pressure:_____/______ Temperature:_____________

Are you in hospice care? Yes No

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**