



PATIENT REGISTRATION

Date: _____ Referred by Dr. _____ Drug Allergies: _____

Has any of your family been treated here? Who _____

If your injury took place at work please notify the receptionist.

PATIENT INFORMATION	Patient's Name: _____ Soc. Sec. # _____ <small style="display: block; text-align: center;">Last First Middle</small> Date of Birth: _____ Age _____ Sex _____ Marital Status: _____ <small style="display: block; text-align: center;">Mo. Day Yr.</small> Home Address: _____ <small style="display: block; text-align: center;">Street City State Zip</small> Home Phone: (____) _____ Occupation: _____ Employer or School Name: _____ Work Phone: (____) _____ Work Address: _____ <small style="display: block; text-align: center;">Street City State Zip</small> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> School _____	
RESPONSIBLE PARTY INFORMATION	Responsible Party: _____ Soc. Sec. # _____ Address: _____ <small style="display: block; text-align: center;">Street City State Zip</small> Employer: _____ Occupation: _____ Work Address: _____ <small style="display: block; text-align: center;">Street City State Zip</small> Work Phone: (____) _____ Other Phone: (____) _____ Email: _____ Spouse's Name: _____ Spouse Soc. Sec # _____ Spouse's Employer: _____ Work Phone: (____) _____ Work Address: _____ <small style="display: block; text-align: center;">Street City State Zip</small>	
INSURANCE INFORMATION	#1 Insurance Co. Name: _____ Ins Co. Address: _____ _____ Insurance Phone: (____) _____ ID # _____ Group # _____ _____ Relation: _____ The Insurance is under the name of: (Person) _____ Date of Birth: _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	#2 Insurance Co. Name: _____ Ins Co. Address: _____ _____ Insurance Phone: (____) _____ ID # _____ Group # _____ _____ Relation: _____ The Insurance is under the name of: (Person) _____ Date of Birth: _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
EMERGENCY INFO	IN CASE EMERGENCY (Person <u>NOT</u> living with Patient) Name: _____ Address: _____ Phone No. _____ City: _____ State: _____ Zip: _____ Relationship: _____	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they may refer to these as "Reasonable and customary fees". We do not accept this as payment in full unless otherwise restricted by law or agreement we may have with your insurer. Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT.**

In the event the account is turned over for collection, the collection fees and/or legal fees, including attorney's fees up to 35%, shall be your responsibility. I hereby assign all medical and/or surgical benefits; to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Canyon Surgical Clinic.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original. I hereby authorize said assignee to release all information necessary to secure payment, via Fax Transmittal or hand copy.

SIGNED _____ Date _____
(Must be 18 or older)

COMPLETING INFORMATION SHEET

- a) Without the INFORMATION COMPLETE you will be considered a personal pay account.
- b) We need copies of your insurance card or cards for our files.
- c) Proper group NUMBERS and Social Security NUMBERS of both insurances are required with the name of the person who carries the insurance. We are aware that *not* everyone has 2 insurance companies.
- d) If retired, please list under employer "RETIRED FROM" (List name of company).
- e) RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM.

THANK YOU FOR YOUR COOPERATION. BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

1. **WE EXPECT YOU TO KNOW AND UNDERSTAND YOUR INSURANCE POLICY.**
2. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). **FOR UN-INSURED PATIENTS, WE REQUEST PAYMENT ARRANGEMENTS BE MADE BEFORE YOUR VISIT.**
3. **AS A COURTESY** we will file your INSURANCE. (If you do file your own insurance, you need to pay for your services today.) We do *not* accept what auto insurance pays as payment in full.
4. If your INSURANCE requires a SPECIAL CLAIM FORM, we must have it WITHIN 2 WORKING days or the INSURANCE BILLING will be processed and sent without it.
5. If your visit is related to AN INJURY at work, **YOU MUST REPORT** it to the RECEPTIONIST. A special form needs to be completed. The PATIENT does not file on this work related injury (INDUSTRIAL); **IT MUST BE DONE BY THIS OFFICE.** Patients will continue to receive statements for their record until we are satisfied by the INSURANCE.
6. **PATIENTS WITHOUT INSURANCE WILL BE CASH VISITS.** (Special arrangements can be made for large accounts).

FINANCIAL POLICY

7. a) In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give to their patients complete information in connection with the extension of credit.
b) **BASIC POLICY:** The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
8. **WORKMAN'S COMPENSATION:** In the event it is determined by the Workman's Compensation board that the illness or injury is not a result of a compensated Workman's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
9. **REJECTED CLAIMS:** If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
10. **RETURNED CHECKS:** A \$15.00 handling charge is applied to all returned checks.
11. a) **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorneys' fees and court costs.
b) If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and costs of collection.
12. **MONTHLY STATEMENTS:** You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid, you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50¢ per month.
13. I have read and agree with the Financial Policy of this office.

Patient _____ Date _____

Insured _____ Witness _____