Medical and Surgical Associates, 1930 Tamarack Road, Newark OH 43055

PATIENT REGISTRATION

Patient name _____ Social Security # _____

Male _____ Female _____ Birthdate _____ Age _____ Marital Status: S M D W

Mailing address: _____

City _____ State _____ Zip _____

Home phone: _____ Cell phone: _____

Employer name: _____ Work phone: _____

Email address: _____ Would you like to be contacted by email? Yes No

May we leave a message on your machine/voicemail? Yes No May we leave a message with other residents? Yes No

Who may we speak to regarding your medical concerns?:

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

May we contact this person whenever needed? Yes No (only for emergency)

FOR MINORS ONLY: child lives with _____ both parents _____ Mother _____ Father

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INSURANCE INFORMATION: (Please complete entirely, even if information is the same as above)

Primary Insurance Company: _____ Secondary Insurance Company _____

Policy/ID# _____ Policy/ID# _____

Group # _____ Group # _____

Policyholder's name _____ Policyholder's name _____

Policyholder's SS# _____ Policyholder's SS# _____

Policyholder's DOB _____ Policyholder's DOB _____

Employer name _____ Employer name _____

Relationship to patient _____ Relationship to patient _____

Please read the following authorization and sign at bottom:

I hereby authorize Medical and Surgical Associates, Inc. and/or any of its representatives to disclose medical or other information obtained in the course of my diagnosis and treatment to any government and/or third party (insurance) payer, or any other entity required by law. I permit a copy of this authorization to be used in place of the original, and request payment of any insurance benefits to either Medical and Surgical Associates, Inc. or myself. I further authorize the disclosure of my diagnosis and treatment records, including the charges for the same to any billing service, attorney, or debt collection agency selected by Medical and Surgical Associates, Inc. Said disclosure shall be solely for the collection of the charges incurred for treatment provided by Medical and Surgical Associates, Inc. to me and/or my spouse and children. I will notify you of any changes made in my health status or insurance information.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Signature of Patient or Guardian: _____ Date _____

I hereby give my consent to Medical and Surgical Assocaiates, Inc. to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Prvacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not require to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse furthers services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Revocation: I hereby revoke the consent given above:

Patient/Guardian _____ Date _____

Name printed _____ If not patient, relationship _____

**********PATIENT FINANCIAL AGREEMENT**********

We are committed to providing you with the best possible care. To avoid any questions or problems, we need your assistance and understanding of our financial policy.

1. All co-pays are due at time of service. There is a $5.00 fee for any co-pay not paid on the date the services are provided. Even if you have a secondary insurance that picks up your copay, you are responsible for paying the co-pay. We will abide by the contract we have with your primary insurance company.
2. There is a $25.00 fee for any appointment that is not cancelled 4 hours before your scheduled appointment time. Three consecutive "NO SHOW" appointments will be grounds for dismissal from the practice.
3. Insurance is a contract between you and your insurance company. We will file your insurance claims as a courtesy to you. You agree to pay any portion of the charges not covered by insurance. We will file your insurance claims on time. If not payment is made, the balance is your responsibility. We emphasize that as a medical provider, our relationship is with YOU and NOT your insurance company. We cannot be responsible for any loss of benefits. It is YOUR responsibility to know your policy.
4. Not all services are covered benefits in all insurance contracts. Some insurance companies select certain services they will not cover and regardless of our participation with a plan, payment for any non-covered services will be the patient's responsibility.
5. In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges or co-pays. It is the authorizing parent's responsibility to collect from the other parent if necessary.
6. There is a $40.00 fee for any returned check. Payment will need to be made by cash, credit card, or cashier's check within 14 days for the amount due, and the returned check fee.
7. Accounts over 60 days old are subject to a billing fee.
8. Accounts 90 days old are subject to a $5.00 delinquent fee. Balances will need to be paid in full at this time to avoid dismissal from the practice and the account being sent out to collection.
9. Accounts over 120 days old or accounts for whatever reasons are dismissed from the practice are subject to a $15.00 dismissal fee.
10. Accounts that are sent to collection are subject to the collection agency's fees that are charged to Medical and Surgical Associates, which is usually 30% of the balance sent to collection. The balance includes any interest added, delinquent and dismissal fees..
11. There is a $10 fee for any records transferred to another physician. The fee increases to $25 if you have an unpaid balance at the time of transfer. Once your records have been transferred, no further appointments will be made with our office.
12. There is a $20 fee for any medication prior authorization your insurance requires.
13. There may be a charge for forms filled out by a physician.

Signature of Patient or Guardian _____ Date _____