McKenzie Surgical Group, P.C.

Patient Information

Patient Name: _____ Date of Birth: _____
Last, First, Middle

Mailing Address: _____ Gender: _____
City: _____ State: _____ Zip: _____ Marital Status: _____
Home Phone: _____ Cell Phone: _____ Soc Sec #: _____
Employer: _____ Work Phone: _____ Ok to contact you there? Yes / No
Referring Physician: _____ Family Physician: _____
Preferred Pharmacy: _____ Pharmacy Phone: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

RESPONSIBLE PARTY (If other than patient. Example: parent/guardian)
Name: _____ Date of Birth: _____
Address: _____ Soc Sec #: _____
City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information

Primary
Insurance Company Name:
Name of Policy Holder: _____ Relationship to Patient: _____
Member ID or Policy #: _____ Group # or Claim #: _____

Secondary
Insurance Company Name:
Name of Policy Holder: _____ Relationship to Patient: _____
Member ID or Policy #: _____ Group # or Claim #: _____

Release of Information

I, the Patient/Guardian, authorize information about my health to be released to the following friends/family:

Name: _____ Initials of Patient/Guardian: _____
Name: _____ Initials of Patient/Guardian: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree that, if there is a remaining balance due, every month I will pay no less than 20% of the original balance due, until the balance is paid in full. I agree, in the event of non-payment, to assume the cost of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to McKenzie Surgical Group, P.C.
3. **I understand that in order to conform to CMS documentation requirements, I will inform McKenzie Surgical Group, P.C., of the existence of an Advance Directive.**
4. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to McKenzie Surgical Group, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, if payments are made directly to me or my representative, I will endorse such payments to McKenzie Surgical Group, P.C. I understand that I have the right to request and receive a Notice of Privacy Practices from McKenzie Surgical Group, P.C.

Signature of Patient/Guardian: _____ Date: _____
Printed name of Patient/Guardian: _____

Please Read Other Side

FINANCIAL and PATIENT RESPONSIBILITY INFORMATION

The United States Department of Health and Human Services has adopted privacy standards, "HIPAA Privacy Standards", which protect your health information. The HIPAA Privacy Standards establish rules for when providers and billing agents may use or disclose your health information. Importantly, the HIPAA Privacy Standards also tell us what we cannot do with your health information. Activities that are not permitted under HIPAA will require your written autorization. The HIPAA Privacy Standards allow us to use and disclose your health information, without your authorization, to perform the activities listed below.

Payment: We are permitted to use and disclose you health information to receive payment for our services. For example, we may:

* Contact your health plan or its agens to check your co-payment amount
* Check to see if specific treatments are covered under your plan
* Provide your health plan or its agents with the health information they need to pay for the services McKenzie Surgical Group, P.C. provided

Insurance Coverage: If you do not have insurance, PAYMENT IN FULL OF **$280.00** is expected AT THE TIME OF SERVICE. This amount will apply toward your initial office visit balance. For surgical procedures, PAYMENT IN FULL is expected PRIOR TO TIME OF SERVICE, unless you have made prior arrangements with our billing office.

Insurance Coverage Exclusion: There may be certain services (cosmetic procedures, as determined by your health plan or services not deemed medically necessary by your health plan) that are not covered by your insurance plan. If so, payment is expected at the time of service, or in the case of surgery, prior to the time of service.

Plan Participation: Although this practice accepts most insurance plans, it is virtually impossible for our office to verify whether or not our physician is covered on your particular plan. So we must ask that you confirm participation status directly with your insurance plan before coming in for your appointment. We will not be held responsible for non-coverage of a visit from a plan which we are not part of the network. You will be expected to pay all balances.

Copays: All insurance copays are due at the time of service.

Referrals: If you belong to an insurance that requires a referral for specialist care, it is your responsibility to make sure the referral is in place prior to your visit to our office. Our agreement with your plan does not allow us to see you until we have a completed referral.

Please understand that insurance remibursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny or reduce payments. However, sometimes involvement from the subscriber (you) is essential in expediting the payment process of a claim by your insurance plan. We would greatly appreciate your prompt attention to any materials or questionnaires your insurance company may send to you by responding to them immediately, as payment of the claim(s) may be pending your response to such inquiries.

If your are unable to make immediate payment of your plan deductible or co-insurance, or if you do not have insurance (or services are not covered by your insurance plan) and you are unable to pay in full at the time of your visit, please discuss the matter with our billing office prior to your appointment. In such situations, we are often times very amenable to developing creative reimbursement plans PRIOR to services being rendered.

You will recive a monthly statement with your account balance. If you have insurance, your statement will show what has been determined to be your responsibility from the response of the carrier.

We are participating with Medicare. We do accept assighment on Medicare claims. The patient is still responsible for payment for certain supplies and services which may not be covered by Medicare.

****REMEMBER, YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE BILL AS A COURTESY TO YOU BUT YOU REMAIN RESPONSIBLE FOR TIMELY PAYMENT ON YOUR ACCOUNT.**

No surgeries will be shceduled if a patient has an outstanding delinquent balance, except in case of an emergency.

Missed Appointments: If you are unable to keep your appointment, we request that you give us at least 24 hours advance notice of your cancellation. If you, on multiple occasions, "no show" without calling us, you may be discharged from our practice.

Divorce Decrees: This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The financial responsibility for minors rests with the accompanying parent. If the other parent is responsible for health care coverage, you must make us aware of this and provide us with all insurance information.

Other Legal Issues: Although we may be sympathetic to your cause, we are not a party in any pending litigation you may have filed and we expect payment in full for services.

Patient Financial Statement of Responsibility: It is our payment policy to collect the appropriate payment due from the patient at the time of service. This may only be your "co-payment", "deductible" an/or "co-insurance" according to your health insurance company or by information supplied by you (the patient and/or subscriber). We anticipate payment responsibility from you for one of the above mentioned reasons and ask that you pay at the time of service.

Thank you!