Surgical Associates, PC

575 South 70th Street, Suite 310
Lincoln, Nebraska 68510
Phone 402-441-4760
Fax 402-441-4764

PLEASE NOTE, THIS INFORMATION IS NECESSARY TO PROVIDE THE SUPERIOR CARE YOU DESERVE. PLEASE COMPLETE IN ITS ENTIRETY.

What Pharmacy/location do you use? _____ How did you hear about our office? _____

PATIENT INFORMATION:

Family Doctor: _____ Referring Doctor: _____

LEGAL NAME: _____
LAST FIRST PREFERRED NAME MIDDLE INITIAL

SEX: ☐ Male ☐ Female DATE OF BIRTH: _____ AGE: _____ SOC SEC #: _____

EMAIL: _____ MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

HOME ADDRESS: _____
STREET P.O BOX

_____ HOME PHONE: (____)_____
CITY STATE ZIP CODE

CELL PHONE: (____)_____

EMPLOYER/WORK:

CIRCLE ONE: EMPLOYED UNEMPLOYED SELF DISABLED RETIRED STUDENT

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____
STREET CITY STATE ZIP CODE

WORK PHONE: (_____)_____

May we leave messages at your home/or your place of employment? Yes No Signature_____

ARE YOU HERE FOR A WORK RELATED INJURY: Y N DATE OF ACCIDENT: _____/_____/_____

EMERGENCY CONTACT:

Do you consent to release of information to this contact: Yes No

NAME: _____ RELATION: _____
(LAST, FIRST, M.I.)

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: (_____)_____ BUSINESS PHONE: (_____)_____

PLEASE LIST AN ALTERNATE NUMBER (CELL PHONE, ETC.) (_____)_____

INSURANCE INFORMATION:

PLEASE HAVE INSURANCE CARD AVAILABLE FOR COPYING

DO YOU CURRENTLY HAVE HEALTH INSURANCE? Yes No

DO YOU HAVE MEDICARE? _____ MEDICARE #: _____

DO YOU HAVE MEDICAID? _____ MEDICAID #: _____

INSURANCE THROUGH: EMPLOYER _____ SPOUSE _____ PARENT _____ INSURED'S EMPLOYER_____

INSURANCE COMPANY NAME: _____

NAME OF POLICY HOLDER: _____ BIRTH DATE: _____ SOC SEC # _____

POLICY ID#: _____ GROUP #: _____

If you have additional policies, please provide this information on a separate sheet.

*****IF YOU ARE CURRENTLY RECEIVING MEDICARE BENEFITS, PLEASE COMPLETE THE MEDICARE BENEFICIARY INFORMATION*******

AUTHORIZATION FOR TREATMENT

Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medical treatment by Surgical Associates, PC, and students in educational programs affiliated with Surgical Associates, PC. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

Patient signature _____ **Date** _____

If patient is an emancipated, adult, patient can sign for self.
If patient is under the age of 19, incapacitated, or ward of state must have signature below.

Guardian/
Parent Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

I agree that Surgical Associates P.C. will bill and provide necessary health information to any Payers. Payers are any health insurance plans or policies, private or government, that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to Surgical Associates P.C. My signature I agree that unless Surgical Associates P.C. has agreed with the Payer to accept payment from Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance and amounts for non-covered services.

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Surgical Associates P.C. for any services furnished me by Surgical Associates P.C. I authorize any holder of medical information about me permission to release to CMS and its agents, any information needed to determine these benefits or the benefits for related services. If applicable, I also authorized payment of Medigap benefits to Surgical Associates, P.C. for all claims filed on my behalf.

I have received and agree to the Financial Policy of Surgical Associates P.C.

Signature _____ **Date** _____

DISCLOSURE OF INFORMATION

I consent to the disclosure of my health information to non-Surgical Associates, PC related health professionals or entities for treatment, billing, and other health operations purposes. This consent will remain in effect unless revoked.

I agree to the sharing of medical information with my family, friends or others as allowed by law when it reasonably appears they are directly involved with my treatment, medical decisions or payment of care. If I do not agree, I will ask for a restriction request to limit sharing of my information. The sharing of medical information with family, friends or others does not give them permission to obtain copies of my medical record.

I am aware that at any time I can request and will receive a copy of the SAPC Privacy Policy for health care information from the staff at SAPC, which includes electronic access to medication history. I understand that SAPC has the right to change its Notice of Privacy Practices at any time and that I may contact SAPC at any time to obtain a current copy of the Notice of Privacy Practices.

I agree, in order for Surgical Associates, PC to service my account or to collect any amounts I may owe, SAPC may contact me by telephone or any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. SAPC may also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that SAPC may contact me as described above. This authorization is also expressly conveyed to any contractor, agent, third-party, individual or others authorized by this facility or its providers to assist with the resolution or collection of any indebtedness to any party for any reason.

Signature _____ **Date** _____

Medicare beneficiaries age 65 or over:

1. Is this injury or illness covered by workers compensation? ○no ○ yes
   If yes, list employer name and address_____
2. Are these services a result of an accident? ○no ○ yes
   If so, what type of accident and who is the responsible party?_____
   Name and policy number of the auto, non-auto liability or no-fault insurer?_____
3. Are you covered by the Federal Black Lung Program? ○no ○ yes
4. Has the Department of Veterans Affairs (DVA) agreed to pay for services at this facility? ○no ○ yes
5. Are these services covered by any other Public Health Service (i.e. Indian Health Services)? ○no ○ yes
6. Are the services to be paid for by a government program or research grant? ○no ○ yes
7. Are you entitled to Medicare because of(Check one or multiple: Age_____ Disability_____ End Stage Renal Disease_____
8. Is the patient 65 years of age or older? ○no ○ yes
9. Is the patient currently employed by an employer of 20 or more employees? ○no ○ yes
   If yes, are you covered under your employer's group health plan? ○no ○ yes
   If no, what was your retirement date?_____
10. Is the patient's spouse currently employed by an employer of 20 or more employees? ○no ○ yes
    If yes, are you covered under your spouse's employer's group health plan? ○no ○ yes
    If no, what was your spouse's retirement date?_____