COLON RECTAL SURGICAL ASSOCIATES, LLC

PATIENT REGISTRATION **WELCOME TO OUR PRACTICE!** **ACCOUNT # ______________**

LAST NAME ________________________________FIRST NAME ____________________________MIDDLE INITIAL ___________

HOME ADDRESS ____ ZIP ______________

HOME PHONE _____________ WORK PHONE _____________ CELL PHONE________________ BIRTH DATE ___________________

SEX___M ___F SOCIAL SECURITY # ___________________________ MARITAL STATUS _______S ______M ______W ______D

EMPLOYER ___________________________________ EMPLOYER'S ADDRESS ____

EMERGENCY CONTACT ____PHONE_________________________

REFERRING PHYSICIAN ___________________________ADDRESS/PHONE____

PRIMARY CARE PHYSICIAN_________________________ADDRESS/PHONE____

PRIMARY INSURANCE CO __________________________________ GROUP # ________________ ID # ____________________

INS CO ADDRESS ____ PHONE # ___________________

POLICY HOLDER'S NAME ____ POLICY HOLDER BIRTH DATE___________________

ADDRESS ____CITY/STATE_____________________________ ZIP CODE___________

PHONE # ______________________ RELATIONSHIP TO PATIENT _____ SELF _____ PARENT _____ SPOUSE _____ OTHER

POLICY HOLDER'S EMPLOYER ____ EMPLOYER'S PHONE # ___________________

SECONDARY INSURANCE CO ________________________________ GROUP # ______________ ID # ____________________

INS CO ADDRESS ____ PHONE # ___________________

POLICY HOLDER'S NAME ____ POLICY HOLDER BIRTH DATE__________________

ADDRESS ____CITY/STATE_________________________ ZIP CODE____________

PHONE # _______________________ RELATIONSHIP TO PATIENT _____ SELF ____ PARENT ______ SPOUSE _____ OTHER

POLICY HOLDER'S EMPLOYER ____ EMPLOYER'S PHONE # ______________________

I recognize and agree that I am responsible for payment of all medical services provided for me or my legal dependent by the physicians of Colon Rectal Surgical Associates LLC, regardless of my insurance coverage, and that payment is due within thirty (30) days of the date payment is requested. I agree that in the event that my account must be turned over for collection, I will be responsible for collection fees, attorney fees, court costs and interest.

I hereby authorize Colon Rectal Surgical Associates, LLC to apply for benefits for any covered services rendered and I request the direct payment of authorized medical benefits (including Medicare, Medigap, Major medical benefits) be made to **Colon Rectal Surgical Associates, LLC** for any services furnished by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I permit a copy of this authorization to be used in place of the original copy. This agreement will remain in effect until I revoke in writing, this authorization.

____ ____

SIGNATURE SEAL DATE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are hundreds of different insurance policies and managed care options. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in colon and rectal care, not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Does your insurance require a referral from your primary care physician? Have you obtained that referral? The referral must be received by the time of your visit or you will be required to pay for the service. Many managed care plans do not issue referral numbers after the date of service. Look at your insurance card. A toll free number is usually listed on the back of the card. Someone with your insurance company should be able to answer your questions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks and balances older than thirty (30) days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advanced notice.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

- I hereby understand that I am responsible for giving "Colon Rectal Surgical Associates, LLC" the correct insurance information.
- I am also responsible for obtaining the proper referral.
- I agree to pay for services for which I failed to obtain a proper referral.
- I agree to pay for non-covered services under my insurance plan.
- I have read, understand and agree to the above information.

Signature:____SEAL

Date:____