

*Advanced Surgical Associates, P.A.*

**Patient Information**

**Account #** \_\_\_\_\_

**Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Birthdate** \_\_\_/\_\_\_/\_\_\_

**Sex:** \_\_\_M\_\_\_F **Marital Status:** Married Single Divorced Widowed Separated

**Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone#**( ) \_\_\_\_\_ **Cell#**( ) \_\_\_\_\_ **SS #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employer** \_\_\_\_\_ **Phone #** ( ) \_\_\_\_\_

**Address** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Referring MD** \_\_\_\_\_ **Primary MD** \_\_\_\_\_

**Insurance Information**

**Subscriber** \_\_\_\_\_ **Birthdate** \_\_\_/\_\_\_/\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Subscriber Employer** \_\_\_\_\_ **Phone#**( ) \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone #**( ) \_\_\_\_\_

**Relationship** \_\_\_\_\_ **Cell/Work #**( ) \_\_\_\_\_

Insurance Name	Plan	Subscriber	ID #	Group#/ Name
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1) \_\_\_\_\_

2) \_\_\_\_\_

**Payment of Services**

Payment is due at the time services are rendered. Your insurance company may be billed for covered services. If your insurance company is being billed for covered services the balance of the account will be due and payable within 45 days after the date the services were rendered. Any unpaid balance and/or noncovered services will be the responsibility of the undersigned. With regard to a minor patient the undersigned (parent or guardian) is responsible for payment.

**Authorization to release information and Authorization to Pay Insurance Benefits**

I hereby authorize Advanced Surgical Associates, P.A. to release medical information to the insurance company(ies) listed above. Also by my signature and copies thereof, I authorize payment directly to Advanced Surgical Associates, P.A. of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If this account becomes delinquent and is turned over for collection, the undersigned agrees to pay all costs of collection, including reasonable attorney's fees. The undersigned agrees to pay interest on all unpaid balance at the rate of 1 ½% per month.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_