Patient Registration Information Form
(Please print clearly and legibly)

Last Name: ___________________________ First: ___________________________ Middle:__________

Date of birth: _______/______/_______ Age: ______ Social Security Number:_____/____/______

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Address: ____ Apt: ____________

City: ____ State: ________ Zip Code: __________

Home phone: (____) _______________ Cell: (____) _______________ Work: (____) _______________

Please call: ☐ my home ☐ my work ☐ my cell
If unable to reach me :

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐ ____

Email address: ____ @ ______________________________

Patient's Employer: ____ Phone: (____) _______________

Spouse's Name: ____ Phone: (____) _______________

Date of birth: _____/_____/_____ Social Security Number: _____-_____-_____

Primary Doctor: _______________________________ Referred by:_______________________________

Pharmacy: ___________________________________

For Minor's only:

Mother: ______________Social Security Number: _____-_____-_____Date of birth: _____/_____/_____

Father: ______________Social Security Number: _____-_____-_____ Date of birth: _____/_____/_____

Authorization to pay: (including Medicare and Medicaid patients)

- I authorize the release of any information that may be required or as pertains to my treatment such as operations, consultations, diagnostic test, physical examinations, etc.
- I permit a copy of this authorization to be used in place of this original.
- Payment directly to the undersigned physician(s), of the surgical and/or emergency medical benefits, including major medical insurance, if any, otherwise payable to me for the services as described above.
- Release of any information to insurance carriers concerning my diagnosis and treatments and I assign to the physician(s) all payments for medical services rendered to my dependents or myself.
- I request that payment under the Medical Insurance Program be made to Surgical Associates of Marshall County on any bills for services furnished to me by them.
- I understand that I am responsible for any amount not covered by insurance or any other entity by this authorization (including services not covered by Medicare or Medicaid.)
- I understand if I have no insurance coverage I am responsible for payment at the time services are rendered.
- I guarantee the payment of all accounts for services rendered at Surgical Associates of Marshall County. For payment of said accounts for services, I hereby waive claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fees.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries, or carriers, any information needed for this or related Medicare claims.
- I request payment of medical insurance benefits to the person who accepts assignment.
- Until my accounts are settled, I give my consent to receive communications regarding my accounts from any services and any collectors of my accounts, through the contact information I've provided.
- I understand that Surgical Associates of Marshall County accepted methods of payment are cash, credit card or debit card. If requested, payment plans may be arranged for special financial situations.

Would you like to receive a copy of our privacy practices? ☐ Yes ☐ No
May we place photographs obtained by our office in your chart for medical purposes? ☐ Yes ☐ No

Release of Information

☐ I authorize the release of information including the diagnosis, scheduling information, claims and billing information. This information may be released to the following:

Name: ______________________ Phone: ______________
Name: ______________________ Phone: ______________
Name: ______________________ Phone: ______________

☐ Information is **not** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

X______________________________ ______________________
Signature Date