Surgical Anesthesia Services, LLP

PATIENT DEMOGRAPHIC SHEET

Thank you for completing this form, *our staff will assist you with all questions*. Your responses *will be kept confidential*.

PERSONAL INFORMATION	**Today's Date: / /**
Surgeon:	Date of Birth (mm/dd/yyyy):
Last Name:	Social Security Number:
First Name: Middle Initial:	Gender: ❑ Female ❑ Male
Previous Name:	Marital Status: ❑ Single ❑ Married ❑ Other_______________
Street Address 1:	Spouse Name:
Street Address 2:	Employment Status: ❑ Full-time ❑ Part-time ❑ Not Employed
City:	❑ Active Military Duty ❑ Self-Employed ❑ Retired ❑ Student
State: Zip:	Employer Name:
Home Phone Number:	❑ OK to leave a message ❑ Do not leave a message
Cell Phone Number:	❑ OK to leave a message ❑ Do not leave a message

Surgical Anesthesia Services is authorized to release information to the following person/entity:

1.	Relationship to patient:
Responsible Party:	City: State: Zip:
Relationship:	Phone:

INSURANCE/ FINANCIAL INFORMATION *(Please submit your insurance card(s) with this form for scanning.)*

Primary Insurance:

Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:

Secondary Insurance:

Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:

By signing below, I acknowledge that the information I provided is accurate to the best of my ability.

Patient/Responsible Party Signature: Date: / /

BILLING AND PAYMENT POLICY

Payment is required in full prior to time of service, unless you have made other arrangements with this office prior to receiving services *(please refer to the Patient Financial Responsibility Policy you received from us)*.

As a courtesy, we will bill your Primary and Secondary insurances for you, if applicable. Any supplemental coverage (e.g. AFLAC or accident coverage) will be your responsibility to bill. Please be advised your insurance may not pay any or only a part of you bill.

INSURANCE REQUIREMENTS

I understand that I am responsible for knowing and understanding my insurance policy including benefits, co-pays, deductibles, covered providers including laboratory and radiology services, anesthesia services, medication formularies and any other medical service requirements including preventive versus diagnostic coding.

______ For Medicare patients: I understand my provider agrees to accept the Medicare allowed charge, and I am only responsible for the deductible, co-insurance and non-covered services.

- I have read, understand and agree to the above payment and insurance policies.
- I authorize this provider or my insurance company to release any information required to process all claims.
- "If either party seeks the counsel of a lawyer for the enforcement of any provision of this contract, then the prevailing party shall be entitled to reasonable attorney's fees, any collection costs and/or court costs."

Patient/Responsibly Party Signature ______ Print Name ______ Date ______

Surgical Anesthesia Services, LLP

Patient Name: **Today's Date: / /**

FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. Your clear understanding of our Financial Policy is important to our professional relationship. Our staff will be happy to assist in answering any further questions you may have. A copy will be provided to you upon request.

Surgical Anesthesia Services provides the anesthesia care for your surgery. This may or may not be covered by your insurance. However, it is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy. We cannot file claims to Workers Comp programs unless your employer has authorized your treatment. We can file automobile-related accident claim if you provide a verifiable auto-insurance claim number.

Patients without insurance coverage or verifiable workman-comp or auto-insurance claim numbers are required to pay the estimated balance in full within forty-eight (48) hours of surgery, unless an arrangement has been approved by management.

Common reasons for insurance claim denials include, but are not limited to:

- Pre-existing medical condition(s)
- Patient responsible for meeting policy deductible
- Insurance not in effect at the time of service
- Coverage by more than one plan in which coordination of benefits has not been arranged
- Policy maximum has been reached
- No referral for the service (if the policy requires you to list a primary care physician)
- Medical services rendered is not covered by the insurance policy

Insurance. We participate with most government and commercial insurance companies. You must provide our office with the necessary billing information for the surgery. Whenever possible we will file your claims with your insurance carrier on your behalf. In most cases reimbursement is be received within 45 to 60 days although there are some exceptions. Knowing your insurance benefits is your responsibility.

Guarantee of Payment. All copays/coinsurance/estimates/deposits must be paid no later than forty-eight (48) hours prior to your scheduled surgery date. You hereby guarantee payment of all charges not paid by insurance, together with all necessary collection expenses. You understand that all bills are payable and become due upon presentation.

Nonpayment. Any unpaid balance is patient's responsibility and payment in full is due upon receipt of the statement. Payment not made within 30 days of the statement issue date is deemed past due and may be reviewed for collections. Payments not received within 60 days of statement date will be sent to the collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's and court fee, if applicable. If you are unable to pay the balance due in full, you must contact our billing office to discuss possible payment options.

Returned Check. A $35 charge will be applied to all returned checks.

❑**INSURANCE PATIENTS** I hereby authorize *Surgical Anesthesia Services, LLP* and its employees to release any/all medical information necessary to process claim(s) to my insurance carrier(s). I irrevocably authorize the insurance carrier(s) to assign all benefits/payments directly to *Surgical Anesthesia Services, LLP.* I understand that I am financially responsible for all charges whether or not my insurance covers those charges.

❑**MEDICARE PATIENTS:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to the provider. I further hereby authorize Medicare or their contracted carrier to furnish to the above named providers of service any information regarding my Medicare claims under Title XVII of the Social Security Act.

By signing below, I acknowledge that I have read and agreed to this Financial Policy.

Patient/Responsible Party or Personal Representative Signature   Date