SURGICAL ASSOCIATES OF ASHEBORO, PLLC

DAVID G. GIMENEZ, MD **RICHARD A. EVANS, MD**

171 MacArthur Street Asheboro, NC 27203

Today's Date __________

Patient Information (Confidential)

Full Name ____ Date of Birth __________

Social Security Number _______________ Home Phone ____________ Cell Phone ____________

Mailing Address ______________________________ City ______________St ___ Zip______

Circle Status: Single Married Divorced Widowed Separated Male ___ Female ___

Employer Name ____Work Phone ____________

Who is responsible for account:____

Insurance Company ________________________________ Employer___________________

Name of Insured _____________________________ Insured's Social Security #______________

Insured's Date of Birth _________ Relationship to patient ___________ Work phone ____________

THERE WILL BE A CHARGE OF $25.00 FOR COMPLETION OF FMLA, DISABILITY, ETC. PAPERWORKWHICH MUST BE PAID WHEN FORMS ARE PICKED UP. WE DO NOT MAIL OR FAX.

Authorization and Release

I authorize and request my insurance company to pay directly to **Surgical Associates of Asheboro, PLLC** benefits otherwise payable to me. I authorize **Surgical Associates of Asheboro, PLLC** to release any and all of my medical and billing information to any physician involved in my treatment, billing, collections, quality assurance and to any other entity which is directly or indirectly responsible for payment or review of services provided by **Surgical Associates of Asheboro, PLLC.** Insurance claims are filed as a courtesy to you if the information provided to our office is accurate, complete and current. In order to do this, we must be able to make copies of your most recent insurance card. Otherwise, you will be responsible for any charges incurred at the time of your visit. You are responsible for any calendar year deductible and/or co-payments, which are due on day of visit. Any balance left owing will be billed once we have received a response from your insurance company. If we do not receive a response from your insurance company within 30 days of our filing date we will bill you for the total balance. **Payment is due upon receipt of bill from this office. We will send one statement and expect payment in full unless you contact us. You are ultimately responsible for your account.**

X____ Date ___________________

Signature of patient or parent if minor

Email Address ____

Medicare/HMO'S Patient Authorization

Medicare Life-Time Signature Authorization: "I request that payment of authorized Medicare Benefits be made to either me or on my behalf to **Surgical Associates of Asheboro, PLLC** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

X____ Date ____________________

Please note: If your HMO/PPO plan requires authorization from your primary care physician in order for you to see a specialist, we must receive a current authorization before your appointment. Please be aware that if we do not have authorization your benefits may be reduced and/or your insurance may not pay anything toward your claim.

HIPAA (Privacy Notice)

Patient Name ________________________________ **Birthdate** __________

Please indicate how you wish this office to contact you:

__ **Home** _____________ ___ **Cell**_________________ ___ **Work**_____________

Does this office have permission to leave messages at any of the above numbers regarding your treatment or other private health information? ____ **Yes** ___ **No**

Please list who we may communicate with regarding your private health information?

Name	Phone	Relationship to you

I authorize Surgical Associates of Asheboro, PLLC to communicate my private health information as instructed above. I was provided with the Notice of Privacy Practices for Surgical Associates of Asheboro, PLLC.

____ _______________

Patient Signature (or authorized representative) **Date**