

GAINESVILLE SURGICAL ASSOCIATES, L.L.C.

Priscilla R. Strom, M.D., FACS

Bradley R. Auffarth, M.D., FACS

Carson K. Agee, M.D., FACS

Gayla M. Royer, M.D.

Date: _____

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Patient prefers to be called: _____ SSN: _____

Mailing Address: _____ Zip: _____

DOB: _____ Gender: M F Marital Status: S M D W Email Address: _____

Physician that **referred** you here today? _____ Home Ph #: _____ Work Ph #: _____

Employer Name and Address: _____

Name and Address of Individual Responsible for bill: _____

Ph #s of Individual Responsible for bill: Home #: _____ Work #: _____

Employer Name and Address of Responsible Individual: _____

Who is your Primary Physician? _____

Name and Phone Number of Individual to Contact in the event of an Emergency: _____

If you have Medicare, is your spouse employed? YES NO If so, where? _____

If we should need to contact you regarding appointments lab results billing questions etc. and you are NOT available to take the call, is there someone you authorize us to give this information to: YES NO

Name of Authorized Individual: _____ Relationship to Patient: _____

May we leave appointment reminders, lab results, etc. on your answering machine or voice mail? YES NO

Best Phone Number to call for appointment reminders, etc.: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insured's Name: _____ SSN: _____

Insured's Date of Birth: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Insured's Name: _____ SSN: _____

Insured's Date of Birth: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

THIS FORM IS CONTINUED ON THE BACK.

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FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file your insurance as a courtesy to you however **YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL**

1. Our office participates with a variety of insurance plans including Medicare and Medicaid. It is your responsibility to:
 - Bring your insurance card at every visit
 - Pay your Co-Payment and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept VISA, MasterCard, Discover and AMEX.
 - Pay in full for any medical care or services that are not covered by your insurance plan.
2. If you have insurance that we do not participate in, our office is happy to file the claim upon request, however payment in full is expected at the time of service.
3. Referrals for HMO, POS, Medicaid or PeachCare: It is your responsibility to bring any required referrals for treatment at or prior to the visit. If you do not have a referral, your visit may be rescheduled or you will be financially responsible for the visit.
4. If the patient is a minor (18 years or younger and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at time of service or any remaining balance after insurance pays and bringing the insurance card and/or any referrals.
5. If you have questions about your insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member services department. The telephone number should be located on your insurance card.
6. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance.

Signature of Understanding:

I have read and understand the above stated financial policy. I accept responsibility for services as outlined above.

Patient or Parent/Guardian if Patient is under 18

Date

PLEASE SIGN BELOW SO WE CAN FILE YOUR INSURANCE:

I authorize the release of medical or any other information about me to my insurance company or the Social Security Administration & Health Care Financing Administration or it intermediaries or carrier, any information needed for this or other related claim, Medicare claim, and/or claim to my private insurance company. I permit a copy of this authorization to be used in place of an original and request payments of any medical insurance benefits from my insurance company directly to Gainesville Surgical Associates. I hereby assign, transfer and set over to Gainesville Surgical Associates all of my rights, title and interest in my medical reimbursement benefits under my insurance policy. This assignment shall remain valid until written notice is given by me. I understand that I am financially responsible for all charges incurred in care and treatment.

Patient or Parent/Guardian if Patient is under 18

Date

Appointments are scheduled specifically for each patient. In order for the doctor to see you as soon as possible, we ask that if you cannot keep your appointment that you cancel at least 24 hours prior to the appointment time.