PATIENT INFORMATION

SOCIAL HISTORY (per week)

Alcohol ☐ Never ☐Beer(s) _____ ☐Week_____ ☐Liquor _____ ☐Wine _____

Tobacco ☐ Never ☐ Current ☐ Discontinued Quantity_____ How Long_____

Caffeine ☐ Never ☐ Current Cups per day_____ Type_____

INSURANCE:

Primary Insured: _____SS# ___-___-_____ DOB: _____

Patient's Name:_____ Relationship to Insured: _____

CREDIT POLICY:

IF YOU ARE NOT A MEDICARE PATIENT OR A MEMBER OF A MANAGED CARE INSURANCE PLAN (HMO, PPO, ETC.) WE ASK THAT PAYMENT FOR OFFICE SERVICES BE MADE AT THE TIME OF YOUR VISIT.

FULL PAYMENT FOR SURGERY AND HOSPITAL SERVICES IS DUE WITHIN 30 DAYS OF FIRST BILLING. FOR YOUR CONVENIENCE, SERVICES MAY BE CHARGED TO YOUR VISA OR MASTERCARD.

IF YOU ARE A MEDICARE PATIENT WITHOUT A SECONDARY INSURANCE, YOU ARE RESPONSIBLE FOR 20% OF THE MEDICARE FEES AT THE TIME OF SERVICE. HOWEVER, REGARDLESS OF INSURANCE COVERAGE, YOU WILL BE RESPONSIBLE FOR ALL AMOUNTS DUE INCLUDING ANY FEES FOR THE SERVICES OF AN ATTORNEY TO COLLECT AN UNPAID BILL FROM YOU AS WELL AS ANY COURT COSTS, IN PREPARATION FOR TRIAL, AT TRIAL, AND ON APPEAL.

GUARANTEE OF PAYMENT:

IN CONSIDERATION FOR THE SERVICES TO BE PROVIDED TO THE PATIENT, THE UNDERSIGNED PROMISE(S) TO PAY SURGICAL ASSOCIATES OF PALM BEACH COUNTY, INC./BOCACARE AND ANY OF ITS PHYSICIANS PROVIDING SERVICES DURING THE PERIOD OF TREATMENT, ALL AMOUNTS LEGALLY DUE AND NOT PAID BY MEDICARE, A THIRD PARTY PAYOR, OR OTHER SOURCE ON MY BEHALF FOR SERVICES RENDERED, WHICH PAYMENT SHALL BE DUE IN FULL AT THE TIME OF COMPLETION OF TREATMENT. IN THE EVENT IT IS NECESSARY TO REFER THIS ACCOUNT TO A COLLECTION AGENCY OR AN ATTORNEY, THE UNDERSIGNED FURTHER AGREES TO PAY ALL REASONABLE COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES. IF MORE THAN ONE INDIVIDUAL EXECUTES THIS AGREEMENT, THEIR LIABILITY SHALL BE JOINT AND SEVERAL.

ASSIGNMENT OF INSURANCE AND MEDICARE BENEFITS:

I AUTHORIZE SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE TO TAKE ASSIGNMENT ON ANY UNPAID INSURANCE CLAIMS. I UNDERSTAND THAT SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE RESERVES THE RIGHT TO REFUSE SUCH ASSIGNMENT OF MEDICAL BENEFITS. IF MY HEALTH INSURANCE WILL NOT ALLOW DIRECT PAYMENT TO SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE OR IF SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE CHOOSES NOT TO ACCEPT ASSIGNMENT OF MEDICAL BENEFITS, I AGREE TO FORWARD TO SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE ALL HEALTH INSURANCE PAYMENTS I RECEIVE FOR CARE AT SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE IMMEDIATELY UPON RECEIPT OF SUCH PAYMENTS.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I ALSO AUTHORIZE SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE TO RELEASE ALL MEDICAL INFORMATION NECESSARY FOR PROCESSING INSURANCE CLAIMS TO ALL INSURERS OR THEIR AGENTS TO THE HEALTH CARE FINANCING ADMINISTRATION (MEDICARE) OR ITS AGENTS.

AUTHORIZATION TO RELEASE INSURANCE INFORMATION:

I AUTHORIZE SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE TO CONTACT MY INSURANCE COMPANY OR HEALTH PLAN ADMINISTRATOR TO OBTAIN ALL PERTINENT FINANCIAL INFORMATION CONCERNING COVERAGE AND PAYMENTS MADE UNDER MY POLICY. I DIRECT THE INSURANCE COMPANY OR HEALTH PLAN ADMINISTRATOR TO RELEASE SUCH INFORMATION TO SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE.

I AGREE THAT THESE PROVISIONS WILL REMAIN IN EFFECT UNTIL OTHERWISE REVOKED BY ME.

PATIENT SIGNATURE_____ DATE _____

PARENT OR SPOUSE SIGNATURE_____ DATE _____