|  |  |  |  |
| --- | --- | --- | --- |
|  **PATIENTS ACCOUNT** | **RESPONSIBLE PARTY** | **CHART NUMBER** | **CATEGORY** |
| **NAME (LAST, FIRST INIT.)** | **OCCUPATION** | **DATE OF BIRTH** | **AGE** | **SEX ( M/F )** | **MARITAL STATUS** |
| **ADDRESS** |  **CITY** |  | **STATE** |  | **ZIP CODE** |
| **SOCICAL SECURITY NO.** | **PRIMARY CARE PYSICIAN/ MEDICAL GROUP**  |  |  | **PCP PHNUMBER** |  |  |
| **EMPLOYER** | **CELL PHONE #** | **SECOND PHONE#** | **WORK PHONE #** |
| **NAME & PHONE # OF FRIEND OF RELATIVE (NOT AT SAME RESIDENCE) EMAIL** |
| **PRIMARY INS. INFO. PLEASE PROVIDE COPY…** | **INSURED’S NAME** | **DATE OF BIRTH** | **RELATIONSHIP TO PATIENT** |
| **INSURANCE CO. NAME & ADDRESS** |
|  |
| **SUBSCRIBER NO.** | **GROUP NO.** | **CPC: Y ES OR NO** | **CO-PAYMENT AMOUNT** **$** |
| **INSURED’S EMPLOYER AND OCCUPATION** | **WORK PHONE** |
| **SECONDARY INS. INFO PLEASE PROVIDE COPY…**  | **INSURED’S NAME** | **DATE OF BIRTH** | **RELATIONSHIP TO PATIENT** |
| **INSURANCE CO. NAME & ADDRESS** |
|  |
| **SUBSCRIBER NO.** | **GROUP NO.** | **EFFECTIVE DATE**  | **CO-PAYMENT AMOUNT****$** |
| **INSURED’S EMPLOYER AND OCCUPATION** | **WORK PHONE** |

I hereby authorize all insurance benefits to be paid directly to ADVANCED ENDOSCOPY CENTER (surgery center). I understand that I am responsible for charges as designated by my insurance companies (e.g. deductibles, co-payments/co-insurance). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize to ADVANCED ENDOSCOPY CENTER to release any information to my insurance companies, to my primary / referring physician / my other physicians/for research institution if and as needed and to any law enforcement agencies or any other governmental agencies if needed.

In consideration of the services to be rendered to me. I hereby individually obligate myself to pay the account of the surgery center I accordance with the regular rates of term of the surgery center. Should the account be referred to an attorney of licensed collection agency for collection. I shall pay reasonable attorney’s fees and collection expenses. All delinquent accounts (those not paid within 60 days from date of service) shall bear interest at the legal rate. I hereby authorize direct payment to the surgery center of any insurance benefits otherwise payable to me for this admission. It is agreed that payment to the surgery center, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment.
I understand that I am financially responsible for charges not covered by this assignment. A photo static copy of this assignment shall be considered effective and valid as the original.

I understand that the surgery center shall have the right at any time to refuse to admit me or provide medical care or treatment to me.

I certify that I am the patient or am duty authorized by the patient as patient’s general agent to execute this documentation and accept its terms.

I understand that, as a courtesy, the surgery center will file my primary insurance. After 60 days from the date of the procedure the total balance will be considered due for payment.

I understand that taking pictures, videos, or any recording on this premises is prohibited.

I authorize ADVANCED ENDOSCOPY CENTER to contact me and/ or have message on my phone listed above regarding appointment and/ or notification.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date SIGNED (Insured or Authorized)