

**Please Bring Completed
Forms with you day of procedure!**

Columbus Surgery Center Patient Information

First Name _____ M.I. _____ Last Name _____ Gender M / F S / M / W
Date of Birth _____ Social Security # _____ Address _____
City _____ State _____ Zip Code _____ County _____
Home _____ Cell Phone _____ E-mail Address _____
Employer _____ Work Phone _____
Family Physician _____ Phone _____ City of Practice _____

Responsible Party (to be used if a patient is under 18 years old) Relationship _____
First Name _____ M.I. _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security # _____ Employer _____

Primary Insurance Information: Insurance Company _____
ID# _____ Group# _____ Policy Holder _____
Birth Date _____ SS# _____ Home Address _____
Employer _____ Employer Phone _____

Secondary Insurance Information: Insurance Company _____
ID# _____ Group# _____ Policy Holder _____
Birth Date _____ SS# _____ Home Address _____
Employer _____ Employer Phone _____

_____ I authorize Columbus Surgery Center to released Protected Health Information via the telephone or in person to the following:
Initial

_____ **Or Any Party Inquiring**

Please list two (2) alternative names & phone numbers of someone (not in your household) that we may contact in case of an emergency or if we are unable to reach you.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

For Office Use Only

I hereby affirm that:

1. I had nothing to eat since _____ or drink (including water) since _____
Date & Time Date & Time
2. I have arranged for transportation home by having _____ phone _____
accompany me so that I will not have to drive. The person named above is a responsible adult and has accepted this responsibility.

Patient/Responsible Party Signature

Employee's Signature & Date

Columbus Surgery Center

Conditions of Service

_____ **Use and Disclosure of Information:** H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I hereby acknowledge that Columbus Surgery Center gave or offered me a copy of the **Notice of Privacy Practices** explains how my information may be used or disclosed. In the event that I have a prosthesis or prosthetic device implanted, I hereby authorize Columbus Surgery Center to furnish or release my name and social security number to the manufacturer of the device for tracking purposes.

_____ **Medicare Certification (for Medicare Patients Only):** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Columbus Surgery Center to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to Columbus Surgery Center, on my behalf.

_____ **Patient Rights and Responsibilities** information received prior to date of procedure or on the same day of service for procedures scheduled as medically necessary.

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail: I authorize the clinical or billing staff of Columbus Surgery Center to leave protected Health Care Information for/about me on my answering machine or voice mail at the number I have listed on this sheet. I understand I may revoke this authorization at any time by submitting my request in writing to this office.

Release Of Medical Information And Authorization To Pay Insurance Benefits: I agree that any benefits of any type arising out of any federal or state program or any policy of insurance for me, or any other party liable to me, are hereby assigned to Columbus Surgery Center for services rendered for which an assignment is applicable. I understand that I am financially responsible to Columbus Surgery Center for charges not covered by this authorization. I certify that the information given by me is accurate and complete.

Financial Agreement: I agree, whether I sign as an agent, guarantor or as a patient, which in consideration of the services rendered to the patient, I hereby individually obligate myself to pay the account of Columbus Surgery Center in accordance with the regular rates and charges. I understand that as a courtesy, Columbus Surgery Center will file my primary insurance claim. After 60 days from the date of surgery, the total balance will be considered due and payable. Should the account be referred for collection, small claim court, or to an attorney, I shall pay reasonable attorney's fees, court fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I recognize that all treating health care providers furnishing services to the patient may submit a separate statement or account from/for each health care provider.

Patient Valuable Disclaimer: I understand that Columbus Surgery Center is not responsible for valuables or personal belongings during my stay at the facility. I assume full responsibility for the loss or damage to valuables brought to the Center.

My signature below certifies that I have read and understand the above information and agree to accept all its terms.

Patient's Signature

Employee's Signature & Date

**Responsible Party's Signature
(For minors or patients unable to sign)**

Relationship to Patient