Surgical Specialties, LLC

Garry Peers MD, FRCSC, Tim Roytman MD FACS,
Andrew Sun MD, Alex Belshoff MD

PATIENT REGISTRATION FORM:

Patient Name: ____SS# ________________ Date of Birth ____/_____/_____

Address: ____ City ________________ State ________ Zip __________

Mailing *(if different)*
Address: ____ City ________________ State ________ Zip __________

Home #: ________________ Leave a Message? Yes / No Cell #: __________________ Leave a Message? Yes / No

Employer: ____ Work #: ______________________

Gender: ___ Male ___Female Marital Status: ____ Single ____Married ____Divorced ____Widow ___Separated

Spouse Name: ____ Date of Birth ____/____/____

Emergency Contact: _____________________________________ Relationship: _____________ Telephone#: ____________

Referring Physician: _____________________________________ Primary Care Physician: _____________________________

Insurance Information

1st Insurance: ______________________________Subscriber's Name: ________________ Relationship ________________

Subscriber# ________________________________Group#: __________________________ Coverage#: _________________

2nd Insurance: _____________________________ Subscriber's Name: ________________ Relationship ________________

Subscriber# ________________________________Group#: __________________________ Coverage#: _________________

I Authorize the Release of Medical Information to my Referring Physician and ____________________________________.

Authorization for Treatment, Release of Information, Assignment of Benefits, and Acknowledgement of Responsibility for Payment of Services:
I hereby give my consent to Dr. Garry Peers, Dr. Tim Roytman, Dr. Andrew Sun, and Dr. Alex Belshoff to provide the necessary treatment. I authorize the release of medical information to my insurer and its agents, physicians, hospitals and other medical providers to determine payable benefits for services rendered. I request payment of authorized Medicare and other insurance benefits be made on my behalf to the above physicians for any services that were provided. This assignment will remain in effect until revoked in writing. I understand that I am financially responsible for all charges incurred and, in the event that insurance payment is sent directly to me, I will remit payment to this office. If my insurance does not pay any bill submitted, I acknowledge these bills are my responsibility and will guarantee payment. I further agree to any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Signature: ____ Date: _________________

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HIPAA

Notice of Privacy Practice Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices which contain a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Privacy Practices from time to time and I may obtain a current copy. Also, I understand I may revoke this Consent in writing at any time. Upon written receipt and confirmation, it shall be revoked.

Patient Name: ____

Relationship to Patient: ____

Signature: ____ Date: ___________________