PATIENT INFORMATION

Patient Name: SS#

Address: City: State: Zip:

Driver License #: State: Gender: ☐ Male ☐ Female

Date of Birth: Age: Marital Status: Home Phone: ( )

Allergies/Drug Hypersensitivities:

Employer: Business Phone: ( )

Business Address City: State: Zip:

Name of Spouse/Parent: SS#

Spouse/Parent Address: City: State: Zip:

Spouse/Parent Home Phone: ( ) *(if patient is minor)* Parent Driver License# State

Spouse/Parent Employer: Business Phone: ( )

EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:

We will be contacting you after your procedure to check on your recovery. Where can we reach you the evening of or day after your procedure? (_____) _____--_____

INSURANCE/PAYMENT INFORMATION:

Type of Payment: ☐ Insurance *(attach photocopy of information)* ☐ Cash ☐ Lien *(attach Lien document)*

Primary Insurance _____ Policy #:_____ Policy Holder: _____

Secondary Insurance Policy #: Policy Holder:

Patient/Responsible Adult Signature: Date:

Patient/Responsible Adult Print Name: *Relationship to Patient

**If signed by person other than patient*

Interpreter (If required) Signature: Print Name

Interpreter relationship to patient (if applicable)

Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name: First M.I. SS#:

Relationship to Patient: Home phone: Date of Birth:

Address: City State Zip

Driver License OR other photo ID: # Type of ID: State issued:

Occupation: Employer: Bus Phone:

Signature of Responsible Party Print Name:

ASSIGNMENT OF BENEFITS- CENTER

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Golden Springs Surgery Center
67555 Palm Canyon Dr., Suite F117
Cathedral City, CA 92234

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Golden Springs Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, charges not covered under my insurance or any balance not covered by the insurance payment.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment. If my insurance company sends me/partner any checks for services provided at the Center, I will immediately bring or mail the check to Golden Springs Surgery Center. Be sure to endorse the check and annotate "Pay to the Order of " Golden Springs Surgery Center" or deposit the check, then send a personal or cashiers check. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

X _____

Patient Signature or Financially Responsible Party | Relationship to patient if not patient | Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

_____

Patient's or Authorized Representative's Signature | Date

_____

Authorized Representative (Please print if applicable) | Relationship to Patient | Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____ Written Communication

☐ OK to speak to :_____

☐ OK to leave message with detailed information ☐ OK to mail to my home address

☐ Leave message with call back number only ☐ OK to mail my work/office address

☐ Work telephone: _____ ☐ OK to fax to _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only ☐ Other

Patient Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the disclosure of, and requests for, PHI to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to the authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information listed below, if completed properly, will constitute an adequate record.

Uses and disclosures for TPO (treatment, payment, operations) may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	**Disclosed to Whom (address or fax number)**	(1)	**Description of Disclosure Purpose of Disclosure**	**By Whom Disclosed**	(2)	(3)

ADVANCE DIRECTIVE

This Center will respect any Advance Directive that may in place. However the Center will NOT implement an advance directive that conflicts with the Center's belief in the sanctity and value of human life. If you bring a copy of an advance directive or living will, a copy will be made and placed in your medical record. Should the need for a transfer to a hospital occur, this copy will be forwarded to the hospital of transfer and they may honor and implement these directives.

The law does not require that patients have or make an advanced directive. Please check one of the following boxes:

☐ Yes, I have provided the Center with a copy of my Advance Directive/ Living Will. The Center has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedures as scheduled.

☐ No, I do not have an Advance Directive/Living Will. I request the facility provide me with information about Advanced Directives. I understand that this Center will not implement an advance directive if I choose to complete one, but will transfer this document with me should the need arise.

☐ I DO NOT have an Advance Directive/Living Will. I DO NOT want information.

X _____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

Office Use Only
Information and Forms Provided to Patient: ☐ Yes ☐ No If NO please comment below