BLUEGRASS SURGERY AND GASTROENTEROLOGY ASSOCIATES

A DIVISION OF UNITED SURGICAL ASSOCIATES, P.S.C.

DATE _____ **PATIENT INFORMATION** **BSGA Account #: _____**

NAME: (LAST) _____ (FIRST) _____ (MI) _____

ADDRESS: _____ CITY/STATE/ZIP: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ GENDER: MALE / FEMALE HOME PHONE #: (_____)_____

SOCIAL SEC. # (SSN): _____ MARRIED? YES / NO SPOUSE'S NAME: _____

RACE: Please Circle (1. American, Indian or Alaska Native, 2. Asian, 3. Black or African American, 4. White, 5. Refuse to Report, 6. Other Pacific Islander, or 7. More than 1 Race)

ETHNICITY: Please Circle (1. Hispanic or Latino, 2. Not Hispanic or Latino, 3. Refuse to Report)

PREFERRED LANGUAGE: _____ Patient email address: _____

MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE? YES / NO CELLULAR PHONE #: (_____)_____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

CITY/STATE/ZIP: _____ EMPLOYER PHONE #: (_____)_____

REFERRING / FAMILY PHYSICIAN: _____M.D. PHONE #: (_____)_____

EMERGENCY CONTACT, OTHER THAN SPOUSE: _____ RELATIONSHIP: _____ PHONE #: (_____)_____

ACCIDENT: WORK RELATED? ___ YES ___ NO AUTO RELATED? ___ YES ___ NO DATE OF INJURY: _____

*** IF YOUR CLAIM IS WORK RELATED, WHO MAY WE CONTACT AT YOUR EMPLOYER TO VERIFY? _____**
(PLEASE NOTE THAT IF WORKER'S COMPENSATION CANNOT BE VERIFIED BY EMPLOYER THAT YOU WILL BE RESPONSIBLE FOR YOUR ACCOUNT BALANCE)

GUARANTOR INFORMATION

(COMPLETE ONLY IF DIFFERENT FROM ABOVE)

NAME: _____ RELATIONSHIP: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE #: (_____)_____

SOCIAL SECURITY # (SSN): _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

CITY/STATE/ZIP: _____ EMPLOYER PHONE #: (_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

INSURED NAME: _____ RELATION: _____ INSURED NAME: _____ RELATION: _____

INSURED'S DOB: _____ INSURED'S DOB: _____

***Ins. Card Copy(ies) to be attached**

ASSIGNMENT OF BENEFITS – AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBILITY

I HEREBY ASSIGN ALL MEDICAL/SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO *UNITED SURGICAL ASSOCIATES, P.S.C./d.b.a. BLUEGRASS SURGERY AND GASTROENTEROLOGY ASSOCIATES DIVISION.* THIS ORDER WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT AND TO COMPLETE DISABILITY FORMS PRESENTED TO ME. I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS FROM OTHER PHYSICIANS AND INSTITUTIONS IN ORDER THAT I MAY BE GIVEN THE APPROPRIATE CARE.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS, FORMERLY HCFA) OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE PARTY WHO ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.) REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS ALSO APPLY.

*** WE WILL FILE ALL CLAIMS AS A COURTESY TO YOUR INSURANCE COMPANY(S) & ALL NECESSARY DOCUMENTATION FOR CLAIM PROCESSING. HOWEVER, IF YOUR INSURANCE COMPANY HAS NOT PAID AFTER 90 DAYS THE BILL IS YOUR RESPONSIBILITY & PAYMENT IS DUE IMMEDIATELY. FURTHERMORE, I, THE UNDERSIGNED, UNDERSTAND THAT IF, FOR ANY REASON, THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, INCLUDING COLLECTION FEES (40%), ATTORNEY FEES (NOT >50%), COURT COSTS & ALL OTHER ASSOCIATED COSTS FOR RECOVERY.**

_____ _____

SIGNATURE OF PATIENT OR GUARANTOR **DATE**