Hartsville Surgical Center, L.L.C

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General & Vascular Surgery, Endoscopy, and Medical Laser Treatment

Patient Information Sheet

Patient's Name (Please Print):_____

(If under 18, list parents' name): _____

Mailing Address:_____ e-mail address_____

City: _____State: _____Zip Code: _____

Home Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____

Employer _____ Phone #: (____) _____ - _____

Date of Birth: ____/____/____ Age: ____ Sex: ☐ Male ☐ Female Race: _____

Social Security Number:_____ - ____ - _____ Marital Status: _____

Spouse's Name:_____ DOB: ____/____/____SSN: _____ - ____ - _____

Emergency Contact Name:_____ Phone #: (____) _____ - _____

Pharmacy Name: _____ Phone #: (____) _____ - _____

Referred By: _____ Phone #: (____) _____ - _____

Family Doctor: _____ Phone #: (____) _____ - _____

Reason for today's visit: _____

BILLING INFORMATION (A copy of Insurance Cards is required)

Primary Insurance : _____ Insured:_____ D.O.B.:_____

Secondary Insurance: _____ Insured:_____ D.O.B.:_____

Other Insurance: _____ Insured:_____ D.O.B.:_____

Authorization & Understanding of Payment Policy

I hereby authorize Hartsville Surgical Center, LLC to furnish to my insurance company information regarding my illness and/or treatment, and I hereby assign to the physicians all payment for medical services rendered to myself or family member. I authorize the use of a photocopy of this assignment in lieu of the original when necessary.

I understand that my insurance is being filed by the provider as a courtesy to me and I am required to do all follow up necessary to ensure payment of my benefits. I understand that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and not a substitute for payment. I also understand that while some insurance carriers will pay fixed allowances for certain procedures and others pay a percentage of charges that I am ultimately responsible for any deductible amount, co-insurance or any other balance not paid by my insurance. I have been advised that verification of benefits is ultimately my responsibility and not that of HSC, LLC. Any services not covered by my insurance company will be my responsibility whether processed in or out of network. If I have no insurance, I understand that I am responsible for paying my balance in full at the time services are rendered to me. I also understand pre-payment of charges may be required prior to non-emergent surgery. If an outstanding balance is owed (regardless of whether patient has insurance), you may be required to settle this debt before any further non-emergent services are rendered. **PLEASE KNOW IF YOU HAVE MEDICARE PRIMARY AND MEDICAID SECONDARY, MEDICAID NO LONGER PAYS AS A SECONDARY AND WE WILL NOT FILE MEDICAID UNLES IT IS APPLIED TO YOUR MEDICARE DEDUCTIBLE. ANY QUESTIONS, PLEASE ASK BEFORE SEEING THE DOCTOR.**

Date: ____/____/____ Signed: _____

Update: ____/____/____ Signed: _____

Update: ____/____/____ Signed: _____

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Please list below any and all individuals (family/friends) that you may want Hartsville Surgical Center, LLC to disclose your protected health record to.

_____

_____

_____

_____

_____

_____

_____

Please print your name, sign and date below

_____	_____	_____
Print	Signature	Date