



PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Do you have a name or nickname that you prefer to be called? _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Date of Birth: _____ Sex: M or F SS# _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Primary Care Doctor: _____

SUBSCRIBER & INSURANCE INFORMATION IF OTHER THAN PATIENT

(Parent's information if patient is a minor)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Home Phone: _____

City: _____ Date of Birth: _____

State: _____ Zip: _____ Sex: M or F SS# _____

Relationship to Patient: _____ Employer: _____

Work Phone: _____

**PLEASE HAVE YOUR INSURANCE CARD AND YOUR
DRIVER'S LICENSE WITH YOU.
WE WILL NEED TO MAKE A COPY.**

If this is a **Workman's Compensation** claim, we will need your Carrier's information,
your Claim number and your date of injury.

ASSIGNMENT OF BENEFITS, PAYMENT TERMS & RELEASE OF INFORMATION

As the Guarantor of this account, I agree to assign to Concord Ambulatory Surgery Center all insurance benefits otherwise payable to or on behalf of the patient for services rendered. I agree to be held financially responsible for services rendered by Concord Ambulatory Surgery Center on behalf of this patient that are not covered by insurance. I understand that it is my responsibility to notify Concord Ambulatory Surgery Center of any changes in insurance coverage. I know that I will pay the balance owed if the insurance or personal information I have given is not true.

I authorize the release of pertinent medical records to the patient's named insurance carrier for the purpose of claims coverage. I understand that this applies to all types of insurance coverage, including but not limited to Medical, Worker's Compensation and Liability/Auto. I understand that the only records released would be pertinent to that date of service and to the carrier providing coverage for that date of service. Failure to provide this authorization may result in the insurance carrier's denial of a claim.

I have read and fully understand the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions on the patient's behalf.

Signature: _____ Date: _____
(Patient/Legal Guardian/Guarantor)