Progressive Surgical Associates

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)

DATE OF BIRTH

STREET ADDRESS

SOCIAL SECURITY NUMBER

CITY, STATE, ZIP

HOME PHONE

E-MAIL (for appointment reminders/confirmations/patient portal access)

CELL PHONE

PATIENT EMPLOYER

EMPLOYER PHONE

EMERGENCY CONTACT AND RELATIONSHIP TO PATIENT

EMERGENCY CONTACT PHONE

CIRCLE THE BEST WAY TO REACH YOU ABOVE

INSURANCE AND GUARANTOR INFORMATION

PRIMARY INSURANCE CARRIER

INSURED NAME AND DATE OF BIRTH

INSURED EMPLOYER

SECONDARY INSURANCE CARRIER

INSURED NAME AND DATE OF BIRTH

INSURED EMPLOYER

GUARANTOR NAME AND DATE OF BIRTH

CHECK IF GUARANTOR ADDRESS/PHONE SAME AS PATIENT ❑

GUARANTOR ADDRESS/ PHONE NUMBER IF DIFFERENT THAN PATIENT

CONTINUED

RACE, ETHNICITY, AND LANGUAGE PREFERENCE

RACE

☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ ASIAN

☐ NATIVE HAWAIIN

☐ BLACK OR AFRICAN AMERICAN

☐ WHITE

☐ HISPANIC

☐ OTHER RACE _____

ETHNICITY

☐ HISPANIC

☐ NON-HISPANIC

☐ DECLINE TO REPORT

PREFERRED LANGUAGE

☐ ENGLISH

☐ INDIAN (INCLUDE HINDI AND TAMIL)

☐ SPANISH

☐ POLISH

☐ OTHER LANGUAGE _____

CONTINUED

Progressive Surgical Associates

AUTHORIZATION TO TREAT

I hereby authorize and consent to treatment/care rendered to me by the physician/medical staff. _____
initial

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I have received and read "Our Financial Policy" and agree to the terms therein. I also understand and agree that such terms may be amended by the Practice from time to time._____
initial

Additionally, I authorize Progressive Surgical Associates to bill my insurance company on my behalf and accept payment from them directly. I know I am required to make any required co-payment amounts, as well as pay for any charges assigned to my deductible, or non-covered services._____
initial

PRIVACY PRACTICES AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PIH), which may include information regarding HIV/AIDS status or mental health records, may be used or shared._____
initial

I hereby authorize my insurance carrier to furnish Progressive Surgical Associates any information obtained in the adjudication of any claim in regard to services furnished to me by them. This authorization is valid until rescinded by me in writing. I authorize Progressive Surgical Associates to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. _____
initial

I acknowledge that Progressive Surgical Associates (PSA), the physicians, the nurses, and other PSA staff may obtain and share any or all of my Protected Health Information, including prescription history, with others in order to treat me, in order to arrange for payment of my bill and for issues that concern PSA's operations and responsibilities._____
initial

I further authorize the disclosure of my Protected Health Information to the following individuals/family members:

_____

Name *Relationship to Patient*

_____

Name *Relationship to Patient*

_____

Name *Relationship to Patient*

I give permission that Progressive Surgical Associates may:

- ☐ Leave a detailed message on my home answering machine or voicemail
- ☐ Call my workplace phone number and leave a message
- ☐ Call my workplace phone number and speak only to me
- ☐ None of the above

X_____

SIGNATURE (OR RESPONSIBLE PARTY IF MINOR) **DATE**