

SURGICAL SPECIALISTS OF COLORADO, P.C.

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PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Please indicate Preferred method To reach you. (____) _____ (____) _____
Home Phone Cell Phone

(____) _____
Work Phone Name of Employer _____

Social Security Number _____ - _____ - _____ Sex M F

Patient Status Single Married Separated Divorced Widowed Child

Email Address _____

*If you receive a prescription for a "controlled" drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMD) when the drug is **dispensed** to you and may be accessed for limited purposes by specific individuals.

INSURANCE POLICY HOLDER OR SPOUSE INFORMATION:

Last Name _____ First Name _____ MI _____ Date of Birth _____

Social Security Number _____ Work Phone (____) _____

Occupation _____ Employer _____

Is Patient a Student? Yes No If Yes, Name of School _____

NEXT OF KIN In case of emergency, give the name of *nearest relative* or *close friend* not living with you.

Name _____ City _____ State _____

Home Phone (____) _____ Work Phone (____) _____ Relationship _____

PRIMARY CARE PHYSICIAN

Name _____ Phone (____) _____

REFERRING PHYSICIAN

Name _____ Phone (____) _____

INSURANCE INFORMATION

Does the Patient have Health Insurance? YES NO

Is this visit related to a work injury? YES NO If YES, Date of Injury: _____

Name of Insurance Contact Person (_____) Phone

Claim # Claims Mailing Address

Is this visit related to an automobile injury? YES NO If YES, Date of Accident: _____

Name of Insurance Contact Person (_____) Phone

Claim # Claims Mailing Address

Primary Health Insurance

Additional Health Insurance

Insurance Company

Insurance Company

Policy Holder

Policy Holder

Relationship to Patient: Self Spouse Child Other

Relationship to Patient: Self Spouse Child Other

ID/Policy #

ID/Policy #

Group #

Group #

Mailing Address

Mailing Address

City/State

City/State

PLEASE READ AND SIGN THE FINANCIAL POLICY OF SURGICAL SPECIALISTS OF COLORADO, P.C. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN PROVIDED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE CONTACT OUR BUSINESS OFFICE TO ARRANGE PAYMENT OPTIONS OR TO DISCUSS ANY INSURANCE QUESTIONS AND/OR FINANCIAL/PAYMENT QUESTIONS YOU MAY HAVE.

I AGREE TO BE RESPONSIBLE FOR ALL PAYMENT OF SERVICES PROVIDED ON MY BEHALF OR MY DEPENDANTS. IT IS ULTIMATELY MY RESPONSIBILITY TO UNDERSTAND THE REQUIREMENTS AND PROVISIONS OF MY INSURANCE POLICY. IF A REFERRAL IS REQUIRED PRIOR TO SEEING A SPECIALIST, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ONE. THE UNDERSIGNED ASSIGNS ALL APPLICABLE INSURANCE BENEFITS/PAYMENTS TO THE PHYSICIAN/PROVIDER OF SERVICE. IT IS FURTHER UNDERSTOOD THAT THE UNDERSIGNED IS FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES THAT ARE NOT COLLECTED AS A RESULT OF THIS ASSIGNMENT. THIS ALSO APPLIES TO NON-COVERED SERVICES PROVIDED AND/OR THE ABSENCE OF INSURANCE COVERAGE AT THE TIME OF SERVICE. I AUTHORIZE SURGICAL SPECIALISTS OF COLORADO, P.C. TO PROVIDE INFORMATION ABOUT MYSELF OR CHILD AND THE CARE GIVEN TO MY HEALTH INSURANCE COMPANY WHEN SUBMITTING REQUESTS FOR PAYMENT OF SERVICES PROVIDED TO MYSELF OR MY MINOR CHILD.

____ **I AGREE TO ALLOW MY PHOTO TO BE TAKEN,** ONLY FOR THE PURPOSE OF INCLUSION IN THE SURGICAL SPECIALISTS OF COLORADO ELECTRONIC MEDICAL RECORD.

____ **I DECLINE TO HAVE MY PHOTO TAKEN**

Patient/Parent of Minor or Authorized Person

Date

PHONE CONSENT:

You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I/We have read this disclosure and agree that we may be contacted as described above.

Signature

Date