

SURGICAL CENTER OF GREATER ANNAPOLIS
PATIENT DEMOGRAPHICS

Date: _____

PATIENT INFORMATION			
Patient's Name (Last, First Middle)		Date of Birth	
SSN (last 4 digits only) XXX-XX-	Age	Sex	
Home Phone	Cell Phone	Email	
Street Address		City	State Zip
INSURANCE INFORMATION			
<i>*Complete only if Patient is not the Insurance Policy Responsible Party*</i>			
Responsible Party	Date of Birth	Phone	
SSN (last 4 digits only) XXX-XX-	Relationship to Patient	Address (if different from above)	
Primary Insurance Company Name:			
Secondary Insurance Company Name:			
HIPAA			
I, the above named patient, allow the Surgical Center of Greater Annapolis to disclose protected health information about me to the parties listed below:			
Name	Relationship to Patient	Primary Phone	
Name	Relationship to Patient	Primary Phone	
<i>A copy of our Policy for the Use and Disclosure of Protected Health Information can be found on the back of this sheet.</i>			
IN CASE OF EMERGENCY			
Name	Relationship to Patient	Primary Phone	
Name	Relationship to Patient	Primary Phone	
<p>Do you have an Advance Directive? An Advance Directive is a written instruction, such as a living will or power of attorney for healthcare describing your wishes in the event you are incapacitated.</p> <p><input type="checkbox"/> I already have an Advanced Directive and, <input type="checkbox"/> I have provided SCGA a copy. <input type="checkbox"/> I did not provide SCGA with a copy.</p> <p><input type="checkbox"/> I do not have an Advanced Directive and, <input type="checkbox"/> I have been provided a copy. <input type="checkbox"/> I would not like a copy provided to me.</p>			
The above information is true to the best of my knowledge. I authorize the Surgical Center of Greater Annapolis to furnish information to insurance carriers concerning illnesses and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. I have had the opportunity to read and understand the SCGA Patient Overdue Balance Policy. I am aware that my surgeon may have financial interest in SCGA. I have also been informed and provided a copy of my Patient Rights and Responsibilities.			
Signature		Date	

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Surgical Center of Greater Annapolis, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Surgical Center of Greater Annapolis, Inc. notice of privacy practices for more complete description of such uses and disclosures.

The Surgical Center of Greater Annapolis, Inc. reserves the right to revise its notice of privacy practices at any time. A revised copy may be obtained by forwarding a written request to The Surgical Center of Greater Annapolis, Inc., Attn: Privacy Officer, 83 Church Road, Arnold, MD 21012.

With my consent, The Surgical Center of Greater Annapolis, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, The Surgical Center of Greater Annapolis, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

I have the right to request that The Surgical Center of Greater Annapolis, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the facility is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Surgical Center of Greater Annapolis, Inc. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the facility has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Surgical Center of Greater Annapolis, Inc. may decline to provide treatment to me.

PATIENT OVERDUE BALANCE POLICY

We accept cash, checks, Visa, MasterCard, and Discover. We also accept Care Credit for balances over \$200. Outstanding balances are due within 30 days of your statement unless prior arrangements have been made with our billing office.

For balances over 60 days, you will receive a final request letter for payment and a \$20 late fee will be added to your balance.

Overdue balances past 120 days will result in the patient not being able to be seen at SCGA unless the balance is paid in full prior to your next surgery date and the patient balance will be sent to a collections agency. You will receive a letter stating the date your account was turned over to collections along with the total balance.

You will have a 30-day grace period from the date of this letter in which we will admit you for emergency services only, allowing you time to find a new source for medical care.