SURGICAL CARE PC

2221 So. 17th St. Suite 303 Lincoln NE 68502
Phone: 476-6626 Fax: 476-1614

Patient's Legal Name:_____Date of Birth:_____

Address: _____City _____ST _____Zip_____

Mailing Address: (If different):_____ City _____ST _____ Zip _____

_____Minor _____Single _____Married _____Divorced _____Widowed _____Separated _____Male _____Female

Social Security # _____/_____/_____ Home Phone _____ Cell Phone _____

Patients Employer _____ Work Phone_____ FT_____PT_____

Spouse, (Parent) Name _____Date of Birth:_____

Employer:_____ Work Phone _____SS#_____/_____/_____

Email Address:_____ Responsible party for billing _____

Primary Care Physician_____ Referring by _____

Emergency Contact_____ Phone Number _____

Insurance: _____Yes _____No Self pay: _____Yes _____No Work Comp: _____Yes _____No

INSURANCE INFORMATION

Insurance card or cards must be presented at the time of service. Staff will make a copy for our records.

****You must present one form of picture identification. This will be photocopied for your chart. ****

AUTHORIZATION AND RELEASE

RELEASE OF INFORMATION: I authorize the release of medical information to any Physician/Medical Facility involved in coordinating my care. I also authorize the release of any medical information necessary to process my insurance /Medicare/ Medicaid/Work Comp claim.

ASSIGNMENT: I hereby transfer and authorize payment to be directly made to Surgical Care P.C for any physician benefits payable by any third party payer. I further agree that this assignment will not be withdrawn or voided until this account is paid in full. I understand that I am responsible for any charges not covered by my insurance. I also understand that payment in full is due upon receipt of statement. Unless payment arrangements have been may ahead of time with Surgical Care PC.

PATIENT'S SIGNATURE: _____ Date: _____

GUARANTOR'S SIGNATURE (MINOR):_____

MEDICARE AND WORK COMP PATIENTS
TURN OVER AND COMPLETE BACK OF FORM

MEDICARE QUESTIONAIRE

COMPLETE THESE QUESTIONS ONLY IF YOU HAVE MEDICARE

MEDICARE REQUIRES THAT ALL MEDICARE PATIENTS ANSWER THE FOLLOWING QUESTIONS:

1. Is the patient a Veteran? ____No ____Yes If yes: A. Did the VA refer you here? ____ No ____Yes
   B. Does the patient have a VA "fee basis ID card"? ____ No ____Yes
2. Do you have a Federal Black Lung Card? ____ No ____Yes
3. Is this medical condition due to an accident? ____ No ____Yes

   If Yes: A Work related? ____ Yes Date of Accident: _____
   B. Auto Accident? ____ Yes Date of Accident: _____
   C. Home Accident? ____ Yes Date of Accident: _____
   D. Other? Describe: _____

4. Are you covered by an employer's health insurance plan, which is **NOT A RETIREE PLAN?** ____ No ____Yes

WORK COMP QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE COMPLETED IN ORDER TO PRE-CERTIFY AND SUBMIT YOUR WORK COMP CLAIM. If at such time your work comp claim would be denied, unsettled or unpaid after 120 days, we will file a claim with your group health insurance. In the event of any legal suits you may file with your employer/work comp carrier, you are responsible for the payment of all charges.

1. Date accident occurred at work: _____
2. Date you reported it to your employer: _____To whom did you report it? _____
3. Describe the accident:
   _____
   _____
   _____
4. Person who authorizes work comp benefits? _____Phone # _____
5. Work comp claims address: _____
   _____
   _____