THE SURGERY CENTER of CENTRALIA
A Community Care Partner

PATIENT STICKER

PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Date of Birth: _____ Sex: Male Female

City: _____ State: _____ Zip: _____ County: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Marital Status: Single Married Divorced Widowed Social Security #: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment: Full Time Part Time Unemployed Retired Student Status: Not a Student Full Time Part Time

Emergency Contact Name: _____ Relationship to Patient: _____ Phone: _____

(Required by State) 1. Race: ☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black ☐ White
2. Ethnicity: ☐ Hispanic Origin ☐ Not of Hispanic Origin

RESPONSIBLE PARTY (If married enter spouse information. If child enter information on parent/guarantor who is completing this form)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Date of Birth: _____ Sex: Male Female

City: _____ State: _____ Zip: _____ County: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Marital Status: Single Married Divorced Widowed Social Security #: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment: Full Time Part Time Unemployed Retired Student Status: Not a Student Full Time Part Time

PRIMARY INSURANCE

Primary Insurance: _____

Insured Name: _____

Insured Date of Birth: _____

Policy #: _____

Group #: _____

SECONDARY INSURANCE

Secondary Insurance: _____

Insured Name: _____

Insured Date of Birth: _____

Policy #: _____

Group #: _____

AGREEMENTS AND ACKNOWLEDGEMENTS

RELEASE OF INFORMATION: I agree that The Surgery Center of Centralia (Center) may disclose my protected health information (PHI) in compliance with HIPAA Privacy Provisions. This includes appropriate release of and disclosure of my medical records when necessary for my treatment, for payment of my account and/or operation of the Center. While I am receiving care at the Surgery Center, I give my permission for the Center to disclose pertinent information to family members, friends or other persons who are accompanying me.

FINANCIAL AGREEMENT: I have been given a copy of the Center's Financial Policy and agree to the Center's payment terms. If my account should become delinquent, I agree to pay all costs, including agency fees, attorney fees, court costs, returned check fees and other related expenses incurred in collecting my delinquent account.

ASSIGNMENT OF BENEFITS: I authorize direct payment to the Center of any insurance benefits. I understand that I am responsible for any charges not paid by my insurance. I further understand that if a check for the Center's services is mailed to me, I will immediately send the check to the Center for payment of my account.

ACKNOWLEDGEMENTS: I acknowledge receipt of the following information:

☐ Patient Rights & Responsibilities ☐ Advance Directive Info/Policy ☐ Disclosure of Physician Ownership ☐ Privacy Notice

I certify that I have read this document and am the patient or am duly authorized to execute it and accept its terms. I further acknowledge that the information stated above is accurate and complete to the best of my knowledge.

Patient/Responsible Party Signature	Relationship to Patient	Date	Witness Signature