



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

**SPOUSE INFORMATION, if married. (If patient is a 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 fees, including collection fees of twenty-seven percent, 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