Southwest Washington Surgery Center

Patient Name	Surgeon	Account #

AUTHORIZATION FOR TREATMENT: I authorize treatment of the patient name below. I understand that it may be necessary to test the patient's blood while at SWRSC to protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS). If, for example, a surgery center employee or physician is stuck by a needle while drawling blood or sustains a scalpel injury, I understand and consent that the patient's as well as the employee's or physician's blood may be tested (as appropriate). I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with state law.

FINANCIAL RESPONSIBILITY: I agree to pay all fees and charges for treatment of the patient named on this form. I understand that payment of my personal balance is due at the time of service, unless I have a payment plan on file, approved and signed by an authorized representative of SWRSC. If SWRSC has a contract with my insurance plan, my co-payment and deductible are due at the time of service and my coinsurance must be paid immediately upon adjudication of my insurance claim. If my account becomes delinquent, it may be assigned to a collection agency. At that time I will be responsible for all interest and fees charges by the collection agency.

NOTE: YOUR ANESTHESIOLOGIST AND /OR SURGEON WILL BILL FOR THEIR SEVICES SEPARATELY.

ASSIGNMENT OF INSURANCE BENEFIT: I request that payment under my medical insurance plan/government health insurance program, for services provided by SWRSC, be made directly to SWRSC.

RELEASE OF INFORMATION: I authorize release of private health information (PHI) and all other information necessary to process my insurance claim or to collect payment of my bill. If I am eligible for Medicare, I authorize SWRSC to release to the Social Security Administration or it's intermediaries or carriers any information needed for this claim or any related claim. I further permit a copy of this authorization to be used in place of the original.

PRIVACY NOTICE: I have received a **PRIVACY NOTICE** describing SWRSC's privacy practices and my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). X_____(patient initials)

DATE OF INJURY

IS YOUR SERVICE TODAY RELATED TO A WORK COMP INJURY? YES_____ NO_____

IS YOUR SERVICE TODAY RELATED TO A MOTOR VEHICLE ACCIDENT? YES_____ NO_____

IS YOUR SERVICE TODAY RELATED TO A 3RD PARTY LIABILITY ACCIDENT? YES_____ NO_____

PATIENT

SURGERY DATE	PATIENT'S NAME (LAST, FIRST MIDDLE)	SEX	BIRTHDATE	SOCIAL SECURITY #	WORK PHONE	CELL PHONE

STREET ADDRESSS	CITY,STATE	ZIP	HOME PHONE

EMPLOYER	EMPLOYER PHONE #

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE #

SPOUSE/PARENT

SPOUSE, PARENT OR LEGAL GAUARDIAN NAME	SOCIAL SECURTIY NUMBER	BIRTHDATE	RELATIONSHIP

STREET ADDRESS	CITY, STATE	ZIP	PHONE #

EMPLOYER	EMPLOYER PHONE #

INSURANCE

PRIMARY

SUBSCRIBER NAME	BIRTHDATE	SUBCRIBER MEMBER #

PLAN	INSURANCE CARRIER ADDRESS	GROUP #

SECONDARY

SUBSCRIBER NAME	BIRTHDATE	SUBSCRIBER MEMBER #

PLAN	INSURANCE CARRIER ADDRESS	GROUP #

SIGNATURE:	DATE:
RELATIONSHIP TO PATIENT:	REGISTRAR INITALS:

ADMISSION RECORD