

Ozark Surgical Associates, LLC

Who Referred You _____

Patient Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Sex (Please Circle) Male Female E-mail address _____

SSN# _____ Date of Birth _____ Age _____

Please circle one: Married Widowed Single Separated Divorced Minor

Employer _____ Occupation _____

Spouse Name _____ DOB _____ SS# _____ Employer _____

What Pharmacy Do You Use _____ Phone# or address _____

(If other than patient or if patient is a minor who is the responsible party)

Primary Insured's Name _____ DOB _____

Primary Insured's Employer _____ SS# _____

Phone Numbers

Home _____ Business _____ Ext _____ Cell _____

In case of Emergency, Contact:

Name _____ Relationship _____ Phone() _____

Release of Information: I understand Ozark Surgical Associates will make every effort to treat my medical information as confidential; however, I realize information must be shared with providers and/or individuals involved in my care or in the payment of my care. I understand this will include information found in my medical record. I agree to the release of information in my medical record, and to the actual medical record documents, to the extent necessary for the following purposes: to those responsible for collection and those responsible for the payment of my care. This may include a person, Medical government agency, insurance company, health plan or employer sponsored group plan.

Assignment of Benefits:

In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by Ozark Surgical Associates and all attending physicians. I hereby irrevocably transfer to Ozark Surgical Associates and all attending physicians, all Medicare/insurance benefits now due and payable to me under any Medicare/insurance policy or policies thereof that might be applicable. I hereby transfer payment of benefits for medical and/or surgical services rendered by physicians for whom Ozark Surgical Associates is authorized to charge and bill.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered.

I HEREBY AUTHORIZE ELECTRONIC BILLING FOR ALL MY CLAIMS. A copy of this signature is as valid as the original and is in effect until I revoke it.

Signature Relationship if other than Patient Date