COLUMBIA GORGE SURGERY CENTER
PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME FIRST: ____________________________ MIDDLE INITIAL: _____ LAST: __________________________________

BIRTH DATE: ______________ AGE: ______ SOCIAL SECURITY NUMBER: _______________________

ADDRESS: ____ CITY: ___________________ STATE: ______ ZIP___________

HOME PHONE: ___________________ CELL PHONE: ___________________ WORK PHONE: __________________ EXT: ______

SEX: MALE FEMALE MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED

IF THE RESPONSIBLE PARTY IS **NOT** THE PATIENT PLEASE FILL OUT THIS SECTION

RESPONSIBLE PARTY'S NAME FIRST: ________________________ LAST: ________________________________

ADDRESS: ____ CITY: ___________________ STATE: ______ ZIP___________

HOME PHONE: ___________________ CELL PHONE: __________________ WORK PHONE: __________________ EXT: ______

BIRTH DATE: ______________ SOCIAL SECURITY NUMBER: _________________________

☐ RESPONIBLE PARTY IS A POLICY HOLDER FOR PATIENT ☐ PRIMARY INSURANCE HOLDER ☐ SECONDARY INSURANCE HOLDER

INSURANCE INFORMATION

PATIENT IS THE: POLICY HOLDER RESPONSIBLE PARTY DEPENDENT

PRIMARY INSURANCE: _______________________________ INSURED'S NAME: ____

ID NUMBER: ____GROUP NUMBER: _________________________

SECONDARY INSURANCE: _______________________________ INSURED'S NAME____

ID NUMBER: ____GROUP NUMBER: _________________________

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment directly to the facility named above of all benefits due me under Medicare, Medicaid or any insurance policy providing benefits for facility charges, for services rendered by the facility. **Photo static copy of this agreement shall be considered effective and valid as original**

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a)any affiliate of the facility, specifically including its employees and agents, including entities under contract with same to provide quality and/or utilization review: (b)any person or entity responsible for all or part of the facilities charges, specifically including any insurance company, their agents, or employees: (c) any person or entity to whom I have been referred by the facility or by my physician for continued care: (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents: (e) the health care financing administration, or other governmental or accrediting agency, or their agents or employees

all facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or the contract between the facility and a third party payer. I HEARBY AGREE WETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney fees and collection expenses whether a suit is filed or not. Delinquent accounts and amounts (those not paid within 90 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by the law. I understand that the facility files for reimbursement from my insurer or other payer as a courtesy, and failure on the part of the insurer to makes payment shall not relieve me of my obligation to pay the facility. Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier. Do not sign this agreement unless you understand its contents.

I certify that I am the patient or I am financially responsible for the services rendered, and do hereby unconditionally guaranty the payment of all amounts when and as due.

SIGNATURE:____ DATE: _______________