GWINNETT SURGERY CENTER, LLC
PATIENT INFORMATION

Place Sticker Here

PLEASE PRINT

PATIENT

Name (Last-First-Middle)	Sex	Social Security No.	Primary Phone ( )	Secondary Phone ( )

Date of Birth	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Ethnicity	County of Residence

Home Address	City	State	Zip Code

Employer Name	Address	City	State	Zip Code

SPOUSE OR GUARDIAN

Spouse or Guardian	Relationship	Date of Birth	Social Security No.	Home Phone ( )	Business Phone ( )

Address	City	State	Zip Code

Employer	Address	City	State	Zip Code

Nearest Relative or Friend at Different Address	Relationship	Address	Home Phone ( )	Business Phone ( )

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured

Insured Social Security Number	Insured Date of Birth	Policy Number	Group Number

Type of Insurance
☐ Group ☐ Private/Individual ☐ Workers Comp. ☐ Auto Insurance ☐ School Insurance

Address (Where to Submit Claim)	City	State	Zip Code	Phone Number

SECONDARY INSURANCE

Name of Insurance Company	Name of Insured

Insured Social Security Number	Insured Date of Birth	Policy Number	Group Number

Type of Insurance
☐ Group ☐ Private/Individual ☐ Workers Comp. ☐ Auto Insurance ☐ School Insurance

Address (Where to Submit Claim)	City	State	Zip Code	Phone Number

GWINNETT SURGERY CENTER, LLC
PATIENT INFORMATION

I request that payment of authorized benefits be made to **GWINNETT SURGERY CENTER, LLC**. I authorize any holder of my medical information to release to the Centers of Medicare and Medicaid Services (CMS) and any other applicable insurance policies or its agents any information needed to determine the benefits or the benefits payable for related services.

DATE ____________________ **SIGNATURE** ________________________________

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **GWINNETT SURGERY CENTER, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **GWINNETT SURGERY CENTER, LLC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PATIENT SIGNATURE ____

RELATIONSHIP TO PATIENT IF NOT PATIENT ____

DATE ______________________________

ALTERNATIVE CONTACT AUTHORIZATION

It is our policy to not release a patient's confidential information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in a voice mail if the name or telephone number is not identified on the message. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete below.

I authorize the Gwinnett Surgery Center, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Center, in writing, whenever the information changes.

I ☐ **DO** ☐ **DO NOT** ☐ **N/A** authorize **GWINNETT SURGERY CENTER, LLC** to contact me or leave messages for me at my place of work.
Date:________________ Initials: _______________

I ☐ **DO** ☐ **DO NOT** authorize **GWINNETT SURGERY, LLC** to contact me at my e-mail address.
(e-mail address if authorized:____) Date:________________ Initials: _______________

I ☐ **DO** ☐ **DO NOT** authorize **GWINNETT SURGERY CENTER, LLC** to leave messages on my personal voice mail regarding appointments and to inform me that laboratory results are available. I realize I must call the office to obtain laboratory results.
Date:________________ Initials: _______________

I ☐ **DO** ☐ **DO NOT** authorize **GWINNETT SURGERY CENTER, LLC** to discuss my appointments, medical evaluation, treatment and results to relatives or other persons as indicated:

Authorized person(s) :____/relationship____

Authorized person(s) :____/relationship____

Authorized person(s) :____/relationship____

Date:_______________ Initials: _______________

POS Reorder # 1207795