

PATIENT INFORMATION

Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 City: _____ Email: _____
 State: _____ Zip: _____ DOB: _____ Age: _____
 Marital Status: _____ Gender: _____ SS# _____
 Employer: _____ Work Phone: _____
 Work Address: _____ Occupation: _____

Scheduled Procedure _____

NEXT OF KIN / SPOUSE / RESPONSIBLE PARTY (if the patient is a minor)

Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 City: _____ Email: _____
 State: _____ Zip: _____ DOB: _____ SS# _____
 Relationship to patient: _____

the following information is only required if we are submitting a claim to your insurance company

INSURED/SUBSCRIBER'S INFORMATION

Check here if the same as the patient's information

Relationship to patient: _____ Name: _____
 Home Phone: _____ Address: _____
 City: _____ State: _____ Zip: _____ DOB: _____
 SS# _____ Employer: _____
 Work Address: _____ Work Phone: _____
 Occupation: _____
 Primary: _____ Secondary: _____
 ID# _____ ID# _____
 Group# _____ Group# _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Insurance Co. Name _____ Insurance Co. Name _____
 ID# _____ ID# _____
 Group# _____ Group# _____
 Address _____ Address _____

 Phone _____ Phone _____

I hereby assign, transfer, and set over to Two Rivers Surgery Center, LLC and the physician's associated with my procedure all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible of all charges whether or not they are covered by insurance, and that a monthly finance charge equal to 0.5% of the outstanding balance or \$5.00(whichever is greater) will be assessed on any balance over 90 days delinquent. A photo copy of this authorization will be as valid as the original.

Signature of Patient/Responsible Party _____ Date _____