Southwest Surgical Associates

EXPERIENCED, COMPASSIONATE CARE YOU CAN TRUST.

Physician: ____________________

Account #: ____________________

Patient Information

Patient Social Security Number	Date of Birth	Gender M F
Patient Name		Nickname
Physical Address Apt. #	City, State, Zip	
Mailing Address (if different) Apt. #	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Email	Patient's Relationship to Insured ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other	

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Patient Employment ☐ Full Time ☐ None ☐ Part Time	Student Status ☐ Full Time ☐ None ☐ Part Time	Spouse Employment ☐ Full Time ☐ None ☐ Part Time

Name of Referring Physician or How did you hear about us?	List any immediate family members who are existing patients:
Is today's visit due to a work-related accident? ☐ Yes ☐ No	Work Comp Adjustor Name / Phone #:

Responsible Party Information (Guarantor) - Cannot be patient if patient is a minor.

Name	Date of Birth	Gender M F	Relationship to Patient
Address	City, State, Zip		
Home Phone	Work Phone	Cell Phone	
SSN	Employer		

Insurance Coverage - Primary Carrier

Insurance Carrier / Network	Policy Number	Group Number	Effective Date
Claims Address		Plan Type ☐ HMO ☐ PPO/EPO ☐ POS ☐ Indemnity ☐ OTHER ____________	
Claims City, State, Zip		Insurance Phone #	
Insured's Name (if different than above)	Date of Birth	Gender M F	
Insured's Address	City, State, Zip		
Insured's Employer	Employer Phone #		

Insurance Coverage - Secondary Carrier

Insurance Carrier / Network	Policy Number	Group Number	Effective Date
Claims Address		Insurance Phone #	
Insured's Name (if different than above)	Date of Birth	Gender M F	
Insured's Address	City, State, Zip		
Insured's Employer	Employer Phone #		

Emergency Contact Information

Name	Relationship to Patient	
Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Preferred Pharmacy Name	Pharmacy Phone	

I hereby authorize payment directly to SWSA for medical services rendered. I authorize the release of my medical information deemed necessary in processing the claim. It is my understanding that I am responsible for this amount, regardless of insurance coverage.

Signature	Date

Southwest Surgical Associates, L.L.P.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Southwest Surgical Associates, L.L.P. creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must:
agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________ ____________________

(PATIENT'S NAME PRINTED) DATE

______________________________ ____________________

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

______________________________ ____________________

WITNESS (Optional) DATE

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PERSONS ALLOWED TO DISCUSS MEDICAL INFORMATION

PATIENT FINANCIAL POLICY

Welcome to Southwest Surgical Associates, L.L.P.

Our physicians are dedicated to providing better health for our patients through surgical excellence.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. In order to better serve your needs and clarify any questions that you may have regarding your responsibilities, we have adopted the following financial policy.

If you have any questions, please speak with one of the members of our billing staff at 713-255-6300 and they will answer any concerns related to your insurance claim or balance. Please remember that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

1. **Identification:** As part of our effort to protect your identity as required by law, you **must** present a photo ID at each visit. If you do not have a photo ID, your visit will be rescheduled.
2. **Cash Patients:** Payment is due at the time of service. We accept cash, checks, credit and debit cards.
3. **Insurance Claims:** You will be required to present your current insurance card(s) at each visit so we can file your claim. For medical care not covered by your insurance, payment in full is due at the time of service. If we do not participate with your plan, we will file the claim on your behalf; however, payment in full is expected at the time of service. You are responsible for payment regardless of arbitrary determination of *usual and customary* rates by your insurance company.
4. **Statement Fee: All co-pay, deductible and coinsurance amounts will be collected at the time of service**. Our practice will assess a $10.00 "statement fee" if the co-payment is not paid at the time of service.
5. **Referral/Authorization Requirements:** It is your responsibility to bring any required referrals/authorizations to your visit. If you do not have the required information, your visit will be rescheduled or you will be financially responsible for all charges at the time of service.
6. **Medical Records/Completion of Forms:** There is a $25.00 fee for medical records requested for personal use and the completion of forms (i.e. disability, leave of absence, etc.) that are not associated with the reimbursement of a medical claim to Southwest Surgical Associates. Records requests will require a minimum 48 hour timeframe to process. All fees must be paid at the time of the request to ensure proper handling.
7. **Returned Checks:** There will be a charge of $30.00 for each returned check. Persons knowingly writing bad checks are subject to criminal prosecution by the District Attorney's office.
8. **Statement Procedure:** Once your insurance has paid, we will mail a statement to the address you have provided indicating your balance due. If you have not made financial arrangements within 30 days, your account may be turned over to our collection agency. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing staff promptly for assistance with your account.
9. **Estimate of Fees:** Our fees are appropriately based on geographic location, physician skill, and expertise. If you require surgical services outside of the office setting, an estimate of fees will be provided to you. Please be aware that the surgical estimate will only be an "estimate" for our services unless otherwise specified. You will receive a separate statement from each outside agency for any services provided by them. This may include hospital, anesthesiology, lab, radiology, and surgical assistants. We can **not** guarantee each outside agency used by the medical facility will be in-network with your plan.

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

AUTHORIZATION: (Please initial & sign)

_____I consent to and authorize Southwest Surgical Associates, L.L.P. to treat any condition that I might have and seek treatment for.

_____I authorize Southwest Surgical Associates, L.L.P. to furnish information to my insurance carriers concerning any illness/accident.

_____I agree that I am financially responsible for all charges whether or not covered by my insurance. I have read and understand the Patient Financial Policy.

_____I hereby, irrevocably, assign to the practice/physician all payments for medical services rendered.

Patient Name (please print): ______________________________ **Acct. #** ____________________

Patient Signature (parent if pt. is a minor): _________________________ **Date:** _________________