

CANCELLATION POLICY

If you cannot keep your scheduled appointment and do not cancel 24 hours prior, it jeopardizes another patient from being able to fill the time slot. If you fail to show up for a scheduled appointment 3 times, at our discretion, we may cancel you from our clinic and refer you to the Deaconess Hospital wound care clinic for further services and care.

INSURANCE INFORMATION - Please read the following sections carefully

Medicare, Medicaid, and Tricare patients only:

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Surgical Specialists of Spokane for any services received by that physician/supplier. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

As a courtesy, we bill your insurance company. In some cases, unless you are insured under worker's compensation, you may be responsible for up to the full amount of the charges incurred during your visit. If the doctor you are seeing is a contracted provider under your insurance plan, you may wish to discuss your financial responsibility with the member services department at your insurance company.

I hereby authorize my physician at Surgical Specialists of Spokane to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my physician at Surgical Specialists of Spokane. This assignment of benefits allows our office to collect directly from your insurance company. Without this release, you will be require to pay for your visit at the time the services are rendered.

I understand that I may be responsible for paying for services rendered, including reasonable attorney's fees and costs incurred in the event of any default. The information provided on this form is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

PRIMARY INSURANCE

Company: _____ Insurance Address: _____

Name of Insured: _____ Policy Number: _____

Insured's SSN: _____ DOB: _____ Group Number: _____

Relation to Patient: Self Spouse Child Dependent Other; please explain:

SECONDARY INSURANCE

Company: _____ Insurance Address: _____

Name of Insured: _____ Policy Number: _____

Insured's SSN: _____ DOB: _____ Group Number: _____

Relation to Patient: Self Spouse Child Dependent Other; please explain:

TERTIARY INSURANCE

Company: _____ Insurance Address: _____

Name of Insured: _____ Policy Number: _____

Insured's SSN: _____ DOB: _____ Group Number: _____

Relation to Patient: Self Spouse Child Dependent Other; please explain:

NOTICE OF PRIVACY PRACTICES and IDENTITY THEFT- ACKNOWLEDGEMENT

We need to have permission from the patient or parent/legal guardian to discuss anything related to the patient's healthcare, including appointment information, financial matters, or health history with any member of the patient's family.

Do we have permission to:

- Leave a voicemail message on the contact (home) phone? Yes No
- Leave a voicemail message on the cell phone (if given)? Yes No
- Leave a message at your place of employment? Yes No
- Discuss the patient's medical condition with any member of the family? Yes No

If "Yes," then whom, and what is their relationship to the patient:

Name: _____

Relationship _____

Name: _____

Relationship _____

Name: _____

Relationship _____

I have been offered today, or in the past, the Notice of Privacy Practices and the Notice of Identity Theft from Surgical Specialists of Spokane.

Signature: _____

Date: _____

Printed name if signed on behalf of the patient: _____

Relationship to the patient: _____

Surgical Specialists of Spokane Employee Witness: _____

Thank you for taking the time to fill out these forms. We look forward to serving you!