Patient Registration

Date ___/___/___

Last Name: ________________ First: ____________ MI: _____ Maiden: ____________

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Female ☐ Male

Social Security Number: ___________-_____-___________ Drivers License No.: ________________ State: __________

Marital Status: Single Married Divorced Widowed Partner Name of Spouse/Partner: ________________

Home Address: ______________________________

City: ________________ State: ____________ Zip: ____________-__________

Billing Address: ______________________________

City: ________________ State: ____________ Zip: ____________-__________

Home Phone: ( ) ________________ Work Phone: ( ) ________________

Cell Phone: ( ) ________________ Pager: ( ) ________________

Fax: ( ) ________________ Email: ________________@____________

Primary Care Physician: ________________ Address: ________________

Phone: ( ) _____-___________ Fax ( ) _____-___________

Referring Physician: ________________ Address: ________________

Phone: ( ) _____-___________ Fax ( ) _____-___________

Employer: ________________ Job Title/Description: ________________

Address: ________________ Telephone: ( ) ________________ Ext: ________

Emergency Contact Person: ________________ Relationship: ____________ Phone: ( ) ___________

Address: ______________________________

Pharmacy of Choice: ________________ Phone ( ) ________________

City & Cross Streets: ______________________________

I Am **Allergic** To The Following Medications: ______________________________

PRIMARY INSURANCE INFORMATION

Subscribers Name: ________________ Relation to Patient: ________________

Insurance Company Name: ______________________________

Group Number: ________________ Deductible Amount: ________________

ID#: ________________ Current Balance: ________________

Co-Pay Amount: ________________

Address to Send Claims: ______________________________

City: ________________ State: ____________ Zip: ____________-________

Phone: ( ) ________________ Fax: ( ) ________________

SECONDARY INSURANCE INFORMATION

Subscribers Name: ________________ Relation to Patient: ________________

Insurance Company Name: ______________________________

Group Number: ________________ Deductible Amount: ________________

ID#: ________________ Current Balance: ________________

Co-Pay Amount: ________________

Address to Send Claims: ______________________________

City: ________________ State: ____________ Zip: ____________-________

Phone: ( ) ________________ Fax: ( ) ________________

ASSIGNMENT OF BENEFITS ◉ CONSENT FOR TREATMENT ◉ RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other plan to Sacramento Advanced Laparoscopic Surgery Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I hereby authorize the physicians and agents of Sacramento Advanced Laparoscopic Surgery Associates to perform any medical treatment as deemed necessary.

Print Name: ________________ **Signature:** ________________ **Date:** ____/_____/____

PATIENT AGREEMENTS

CONSENT FOR TREATMENT

I authorize Sacramento Advanced Laparoscopic Surgery Associates to perform such procedures and/or treatment, as the physicians deem necessary.

Initial: _____

RELEASE OF MEDICAL RECORDS

I authorize Sacramento Advanced Laparoscopic Surgery Associates to release the following medical information in order to process and secure payment of charges from my insurance company or its intermediaries.

Medical Condition
Psychiatric/Psychological/Mental Health

I agree to be financially responsible for any service rendered if payment is denied due to my direction to withhold this information from my insurance carrier.

Initial: _____

INSURANCE

I understand that SALSA is under no obligation to facilitate insurance payment, and that any insurance billing is done as a gratis courtesy to me. I understand SALSA makes no representation as to any insurance compensation I might receive. It remains my sole responsibility to review my insurance policy and pursue any insurance monies I am entitled to. I authorize my insurance carrier, or its intermediaries, to make payment directly to Sacramento Advanced Laparoscopic Surgery Associates medical/surgical benefits otherwise payable to me for services rendered. I have been advised of all surgical fees. I accept responsibility for payment of all fees at published rates, unless I have had other arrangements, which are enforceable only if they are in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Initial: _____

PATIENT NAME: ____

PATIENT SIGNATURE: ______________________________ **DATE**: __________

THIS DOCUMENT MUST BE RETURNED TO SALSA BEFORE YOUR FIRST APPOINTMENT

PATIENT RESPONSIBILITIES

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes knowing which facilities can be used for radiology, laboratory, hospitalization or surgery. We request that you bring your EVIDENCE OF INSURANCE COVERAGE booklet to your first appointment, as benefits for bariatric services fluctuate greatly from plan to plan.

The patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician **BEFORE** you schedule an appointment with our office. You will be held financially responsible if a referral/authorization is not obtained prior to your visit.

After your group appointment with SALSA, please contact our insurance/referral coordinator to determine if prior authorization is required for future visits, tests and the proposed surgical procedure. It can take up to three weeks for your insurance company to process an authorization request. Please do not schedule any appointments prior to insurance approval. It is important that ample time be allowed for the authorization process. If the patient opts to begin care before this process has been completed, the patient will be held financially responsible for 100% of the charges at the beginning of your treatment.

After surgery, the authorization we obtain typically includes 2 visits within the 90 day global period. However, this should be confirmed by you. The insurance/referral coordinator can be reached at (916) 797-7555 extension 3, during business hours. If no one is available, leave a voice mail message and your call will be returned.

In order to perform your surgery, we will need payment at your preoperative appointment if you have an insurance we do not have an agreement with. This payment may be paid by cashiers check, money order, Visa/MasterCard and Care Credit. We do not accept personal checks for this payment. A 3% charge is added to credit card payments.

We will help you to the best of our ability, although ultimately, it is your responsibility to understand what provisions, restrictions and requirements are included/excluded in your specific insurance policy.

I indicate by signing below that I have fully disclosed my insurance provider as ______________________.
I hereby represent that I am not a member of Medicare/Medi-cal. I further acknowledge that I have read this notice and am aware of these issues.

______________________________ ____________________

Signature of Patient Date