**PATIENT REGISTRATION**

**PATIENT INFORMATION:**

NAME:_____

SS#:_____ BIRTHDATE:_____

SEX: M F MARTIAL STATUS:_____ DRIVERS LICENSE#_____

ADDRESS:_____

CITY, STATE, & ZIP;_____

HOME PHONE: _____CELL PHONE:_____

EMPLOYER:_____

EMERGENCY CONTACT PERSON:_____

RELATIONSHIP:_____PHONE:_____

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**

NAME:_____

SS#:_____BIRTHDATE:_____

SEX: M F MARTIAL STATUS: _____DRIVERS LICENSE#: _____

ADDRESS: _____

CITY, STATE, & ZIP:_____

HOME PHONE:_____CELL:_____

EMPLOYER:_____

**INSURANCE COVERAGE:**

PRIMARY CARRIER:_____

SUBSCRIBER NAME:_____EFT DATE:_____

ID#_____GROUP#_____CO PAY:_____

CLAIMS ADDRESS:_____

I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the other party who accepts assignment. I authorize payment of medical benefits to the physician for all services rendered. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for services rendered.

Signature:_____ Date:_____

**ADVANCED PELVIC SURGERY, LLC**
**R. Gregory Owens, M.D.**

**7162 Liberty Centre Dr.**
**West Chester, OH 45069**
**Phone: 513/942-7640**
**FAX: 513/755-4736**

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❖ **CONSENT TO TREATMENT/TESTING:** I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.

❖ **RELEASE OF RECORDS:** I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or to their representatives, review organizations, or surveyors for accreditation, regulatory and/or licensing purposes, as necessary to determine benefits entitlement and to process payment claims for healthcare services provided. This authorization shall be valid only for the period of time necessary to process payment claims.

In consideration of admission and all facility services, the undersigned agrees to the following:

❖ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Advanced Pelvic Surgery, LLC of all insurance benefits, otherwise payable to me.

❖ **GUARANTEE OF ACCOUNT:** I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physician for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.

❖ **I have read and do understand this form.**

_____ _____

Signature of Responsible Party Date

_____ _____

Relationship to Patient Witness

# WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: _____

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: _____

**I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES IN THE OFFICE WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.**

***TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:***

1. **CASH – INCLUDES PERSONAL CHECKS**
2. **VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX**
3. **CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:**
   - **Flexible Financing options**
   - **No annual fees or prepayment penalties**
   - **Quick and easy application**
   - **Receive a credit decision almost immediately**
   - **Start your recommended treatment immediately**

SIGNATURE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

DATE: _____

# CONSENT TO DISCUSS

I, _____ give my consent to Advanced Pelvic Surgery

to discuss my medical condition with _____

**Family Member or Friend**

_____ _____

Patient Signature Date