Physicians Alliance Surgery Center
An Affiliate of Saint Francis Healthcare System

Patient Sticker Here

# Patient Information Form

Patient name: _____ Sex: ◯ M ◯ F

SS#: _____ Birth date: _____ Age: _____ Marital status: ◯S ◯M ◯W ◯D

Race (state required): ◯Caucasian/White ◯African American ◯Native American ◯Asian ◯Hispanic ◯Other _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ (cell): _____

Work Status: ◯Part-time ◯Full-time ◯Retired ◯Student ◯Unemployed Occupation: _____

Employer: _____ Employer's Address: _____

Spouse's name: _____ Birth date: _____ SS#: _____

Spouse's place of employment: _____ Spouse's work phone: _____

Name of person staying with you for 24 hrs after surgery_____ Phone: _____

**How did you get hurt? Please explain in detail (How, when, where).** _____

_____

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**If patient is a minor (this section must be filled out completely)**

Mother's name: _____ Father's name: _____

SS#: _____ Birth date: _____ SS#: _____ Birth date: _____

Mother's address: _____ Father's address: _____

_____ _____

Mother's occupation: _____ Father's occupation: _____

Place of employment: _____ Place of employment: _____

Phone (home): _____ Phone (home): _____

(work): _____ (work): _____

Child lives with (circle all that applies):
◯Mother ◯Father ◯Step mom ◯Step dad ◯Grandparent ◯Foster care ◯Other_____

_____

**Please read the following and sign below:**

I hereby authorize Physicians Alliance Surgery Center and S&R Anesthesia to furnish information or records necessary to any party responsible for the settling of this account. A copy of this authorization shall be as effective and valid as the original. I understand that I am financially responsible for all charges whether or not covered, considered cosmetic, or deemed "not medically necessary" by my insurance carrier.

This office cannot accept responsibility for collecting your insurance claim or negotiating the settlement of a disputed claim since we are not a party to your insurance contract. In accidents, legal cases, etc., where a third party is presumed liable for your medical expenses, the party receiving medical services is responsible for payment. This office cannot be expected to wait for court conclusions or disputed insurance claim settlements.

Any balance that is referred to our collection agency will be assessed a penalty of 15%

I hereby authorize Physicians Alliance Surgery Center and S&R Anesthesia to receive direct payment for the amount due me in my pending claim for medical services rendered. I certify that the information that I have provided is correct. I will notify you of any changes in my status or the above information.

Signature of Patient, parent, or Legal Guardian: _____ Date: _____