PARAGON SURGICAL SPECIALISTS

PATIENT INFORMATION

Name ____
(Last) (First) (Middle) (Maiden)

Mailing Address ____

City ______________ State ________ Zip ________ Home Phone ______________

Social Security ______________ Marital Status (Circle One) S - M - W - D

Birthdate ______________ M - F (Circle One)

Cell Number ______________ Email Address ______________

Employer ______________ Work Phone ______________

Address ____

EMERGENCY CONTACT	PRIMARY POLICYHOLDER INFORMATION
Name: ______________	Policyholder's Employer ______________
Relationship: ______________	Policyholder's Name ______________
______________	Policyholder's Date of Birth ______________
	Policyholder's SS# ______________
	SECONDARY POLICYHOLDER INFORMATION
	Policyholder's Employer ______________
Work Phone ______________	Policyholder's Name ______________
	Policyholder's Date of Birth ______________
Cell or Home Phone ______________	Policyholder's SS# ______________

DEDUCTIBLE AND CO-PAYS ARE DUE AND PAYABLE AT TIME OF SERVICE! THIS ALSO INCLUDES SURGERY CHARGES. IF WE ARE NOT CONTRACTED WITH YOUR INSURANCE COMPANY, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. As a courtesy, we will file your insurance claim for your reimbursement.

I will pay my visit by Cash ________ **Check** ________ **Credit Card** ________ **Debit Card** ________

MEDICARE PATIENTS: Your deductible and co-pays are due at the time of service unless you can show your deductible has been met and you have supplemental coverage for your co-payments.
MEDICAID PATIENTS: You must present a copy of your current card in order to be seen. Co-pays must be paid at the time of service. Hospital co-pays are due on your first visit after hospitalization.
WORKERS' COMPENSATION: You must present a claim number & employers phone number. We will call your employer to validate your claim. If it is not authorized, you must pay for today's visit.

➡ Signed ______________________ Date ______________
(Patient)

IF PATIENT IS A MINOR: I, ______________________, custodial
Parent/Legal guardian of ______________________
do hereby give my permission to PARAGON SURGICAL SPECIALISTS to treat him/her. I accept financial responsibility for such treatments.
Date of Birth ______________ Social Security # ______________

Signed ______________________ Signed ______________________ (SEAL)
Witness Parent/Legal Guardian

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY: (In order to file your insurance, you must sign and date this authorization.)

I hereby authorize **Paragon Surgical Specialists** to release any medical and other information necessary to process my insurance claims. I further authorize payment of medical benefits to Paragon Surgical Specialists for my services. I understand this authorization allows the release of all information in my file, including information regarding any chemical dependency problems and/or treatment and HIV testing. I further understand that I may revoke this authorization in writing at any time.

➡ **Patient**/Guardian ______________________ Date ______________