PARAGON SURGICAL SPECIALISTS

PATIENT INFORMATION

Name _____
(Last) (First) (Middle) (Maiden)

Mailing Address_____

City_____State_____ Zip_____Social Security _____

Marital Status (Circle One) S - M - W - D Gender Identity: ☐ Male ☐ Female ☐ Other

Birthdate_____/_____/_____ Email Address_____

Cell Number_____ Home Number_____

How would you like to be contacted for:

Appointment Reminders: Phone___ Text Message ___ Email___

Billing/Insurance Questions: Phone___ Text Message ___ Email___

Employer_____ Work Phone_____

Address_____

EMERGENCY CONTACT

Name:_____

Relationship:_____

_____

Work Phone_____

Cell or Home Phone_____

PRIMARY POLICYHOLDER INFORMATION

Policyholder's Employer_____

Policyholder's Name_____

Policyholder's Date of Birth_____

Policyholder's SS#_____

SECONDARY POLICYHOLDER INFORMATION

Policyholder's Employer_____

Policyholder's Name_____

Policyholder's Date of Birth_____

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 _____

SELF PAY PATIENTS: Your $100.00 initial payment is due at the first visit and you will be required to meet with one of our billing specialists for payment arrangements for the remainder of you balance.

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 _____