PATIENT REGISTRATION

ACCT # _____

DATE _____

DATE _____

FOX VALLEY SURGICAL ASSOC., LTD.

____ Dr. Ballard ____ Dr. Bermas ____ Dr. Black ____ Dr. Cheng ____ Dr. Duppler

____ Dr. Krieger ____ Dr. Klingbell ____ Dr. Tretinyak ____ Dr. Vogt ____ Dr. Winek

PATIENT INFORMATION: (PLEASE PRINT)

Name _____ (first middle last) Birthdate _____ Age ____ Sex: M F

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Social Security No. _____ Marital Status M S D W

Employer _____ Employer's Phone ( ) _____ Ext. _____

Employer's Address _____ City _____ State _____ Zip _____

May we contact you at work? Yes ❒ No ❒ Are you retired? Yes ❒ No ❒

SPOUSE OR GUARDIAN

Name _____ Birthdate _____ Age _____ Phone ( ) _____

Relationship to Patient _____ Social Security No. _____

Address _____ City _____ State _____ Zip _____

Employer _____ Employer's Phone ( ) _____ Ext. _____

Employer's Address _____ City _____ State _____ Zip _____

NAME OF NEAREST RELATIVE OR FRIEND IN AREA (NOT LIVING WITH PATIENT)

Name _____ Relationship to Patient _____

Phone ( ) _____

FAMILY PHYSICIAN: (Full Name) _____

PHYSICIAN REFERRED BY: (Full Name) _____ Cardiologist _____

Please list your insurance(s) in the correct order of coverage.

PRIMARY INSURANCE

Insurance Company _____

Address _____

Policyholder Name _____

Subscriber No. _____

Group No. _____

Effective Date _____

SECONDARY INSURANCE

Insurance Company _____

Address _____

Policyholder Name _____

Subscriber No. _____

Group No. _____

Effective Date _____

THIRD INSURANCE

Insurance Company _____

Address _____

Policyholder Name _____

Subscriber No. _____

Group No. _____

Effective Date _____

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION

Are You Being Seen for a Work Related Injury? Yes ❒ No ❒

Was This Related to an Auto Accident/Accident? Yes ❒ No ❒

Date of Accident or Injury _____

Carrier _____

Claim No. _____

Address _____

City _____ State _____ Zip _____

All bills will be sent to the responsible party if complete insurance information has not been provided.

PAYMENT OF ACCOUNT

I understand and agree that I am responsible for payment of my account regardless of my insurance status. We file claims to your insurance company for you. If they do not respond within 90 days, you will then become financially responsible for the balance.

Furthermore, we charge what is usual and customary for our area. You are responsible for payment regardless of any (commercial) insurance company's discretionary determination of usual and customary rates.

I hereby authorize my insurance carrier to pay Fox Valley Surgical Associates, Ltd. directly for services rendered.

I further authorize Fox Valley Surgical Associates, Ltd. to furnish information to my insurance company(ies) concerning my illness and treatment for the purposes of obtaining reimbursement for medical services provided.

_____ _____

Responsible Party/Patient Signature ***Date***

MEDICARE PATIENTS ONLY

PATIENT SIGNATURE ON FILE FOR MEDICARE CLAIMS

Entitlee's Name: _____
(Last) (First) (MI)

Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Fox Valley Surgical Associates, Ltd. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ ***Date:*** _____

I AUTHORIZE MEDICARE TO FORWARD MY CLAIMS DIRECTLY TO MY SUPPLEMENTAL INSURANCE CARRIER _____
(Name of Insurance Company)

Signature: _____ ***Date:*** _____

This authorization is in effect until I choose to revoke it.