REGISTRATION FORM
(*For Surgery Center)*

Patient Name (last, first, middle or maiden)				*Birth Date*		*Age*	*Sex*
Address (Street Address)			*Apt. No.*	*Marital Status*	*Social Security Number*		
City		*State*	*Zip Code*	*PO Box Address*		*State*	*Zip Code*
Home Phone Number	*Cell Phone*			*Work Phone Number*			
Employer						*Telephone No.*	
Emergency Contact Name						*Telephone No.*	
BILLING INFORMATION - Responsible Person ***Person Responsible*** *(Name)* *Address*				*City*		*State*	*Zip Code*
Patient Relationship	*Date of Birth*	*Social Security No.*		*Home Phone No.*		*Work Phone No.*	
Employer	*Address*	*City*		*State*	*Zip Code*	*Telephone No.*	
INSURANCE DATA – Your ins may require ***Pre-Auth/Referral (pt.'s responsibility to call PCP if Referral is needed****)* ***Primary Insurance***						*Date of Injury:*	
Address	*City*		*State*	*Zip Code*		*Telephone No.*	
ID Number	*Group No.*	*Claim# (for L&I only)*		*Insured Person*		*Relationship*	
Secondary Insurance							
Address	*City*		*State*	*Zip Code*		*Telephone No.*	

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to SW Seattle Surgery Center the benefits otherwise payable to me but not to exceed the balance of the SW Seattle Surgery Center's regular charges for this period of outpatient surgery.

AUTHORIZATION: I hereby authorize release of any medical information necessary to process this claim. I authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's follow up care. I understand that it may be necessary to test the patient's blood while in the surgery center to protect against possible transmission of blood borne diseases such as Hepatitis-B or Acquired Immune Deficiency Syndrome (AIDS). If, for example, a surgery center employee or physician is stuck by a needle while drawing blood or sustains a scalpel injury, I understand and consent that the patient's as well the employee's or physician's blood will be tested. I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with the state law.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to SW Seattle Surgery Center for any amount not covered by this authorization. I will be notified when final action by my insurance carrier has been received by SW Seattle Surgery Center. In the event that this account is placed with an attorney or a collection agency, the undersigned is responsible for collection fees, reasonable attorney fees, and court costs. I also agree by signing this form, I may be charged a 1 ½% finance charge on any balance due after 60 days.

NOTE: YOU WILL BE BILLED SEPARATELY FOR SERVICES PROVIDED BY YOUR SURGEON AND/OR ANESTHESIOLOGIST.

*Date:*_____ *Signed:*_____