Coastal Physicians & Surgeons

Physician:

Name:		Date of Birth:
Address One:		Social Security #:
Address Two:		Sex:
City:		Employer:
State: Zip:	☆	**Emergency Contact:**
Home Phone#:	☆	**Emergency Home Phone#:**
Work Phone#:	☆	**Emergency Work Phone#:**
Cell Phone#:	☆	**Emergency Cell Phone#:**
Preferred # for Automated Reminder:		**Your e-mail:**
Race:	☆	**Ethnicity (circle) Hispanic or Non-Hispanic**
Language: ☆	☆	**Pharmacy Name / City** **Local:** /
Referring Doctor: **Primary Care Physician:**		**Mail Order:** /

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip**
Cell Phone#:	**Employer Phone:** ( ) -

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number: :	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name**
Subscriber DOB:	**Subscriber DOB:**

INJURY DETAILS

Were you injured at work? **Y N**	Date of Accident?
In an Auto Accident? **Y N**	Date of Accident?
Were you injured slip/fall? **Y N**	Date of Accident?
If Slip/fall Where?	
Attorney Involved? Name:	Phone #:
Adjustor Name:	Phone #:
Case Manager Name:	Phone #:

If it is later determined that this treatment results from the occurrence of an underlying work related and/or personal injury action and/or slip and fall, then Coastal Physicians & Surgeons, PC has the right to reverse acceptance of any payment from a private payor and/or health care insurance company and Coastal Physicians & Surgeons, PC has the right to demand payment from any statutory and/or PIP auditing procedure and/or court order.

Our office will submit insurance for you. Please remember you are responsible for all fees, deductibles and co-payments that the insurance company does not cover. Co-payments are due at the time of service. If you do not have insurance coverage or have insurance coverage that we do not participate with payment is due at the time of service.

All HMO's, IPA's and EPO's require prior authorization for each office visit. This is your responsibility. If we do not receive the authorization, payment is due at the time of service.

Authorization To Release Medical Information: I authorize the release of medical or other information necessary for the course of my treatment. I authorize the release of medical or other information necessary to process claims, to physicians requesting consultations, third party payors and/or attorneys responsible for all or part of physician's fees.

Assignment of Benefits: I hereby authorize payment of medical and surgical benefits by my insurance company to this provider.

_____ _____
Signed (patient or parent if minor) Date

You agree, in order for us to service your account or to collect monies you may owe, Coastal Physicians & Surgeons, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Coastal Physicians & Surgeons & Surgeons, PC, its employees and/or agents may contact me/us as described above.

_____ _____
Signed (patient or parent if minor) Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been made aware of this practice's **Notice of Privacy Policies** (a copy of which has been offered to me), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

I Permit the Practice to discuss my medical care with the following family members:

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed : _____
Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____
Witnessed by: _____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

( ) Patient refused to sign this Acknowledgment.
Date: _____ Time: _____
Employee Name: _____