The Su Surgical Group

Name: _____ **Date of Birth:**_____

Address: _____

City, St., Zip: _____

SSN: _____ **Primary Doctor:**_____

Race (please circle one): White Hispanic African American Asian Other Decline to answer

Primary Language: English Other: _____

Referring Doctor:_____

Contact Information: This sections refers to the methods we will contact you or your authorized contact person.

Please circle your preferred method of contact for appointment reminders:
Home phone Mobile Text (your messaging rates will apply) Email

Home Phone: _____ **Cell Phone**:_____

Work Phone:_____ **E-mail address**:_____

Pharmacy: _____ **Location:** _____

Please list who we are allowed to contact in case of emergency or to discuss healthcare matters such as test results and scheduling:
Name:_____ Phone: _____Relationship:_____

Name:_____ Phone: _____Relationship:_____

Insurance and Payment Information

Primary Insurance:_____ Policy#:_____ Group#_____

Policy Holder:_____ DOB:_____ SSN:_____

Secondary Insurance:_____ Policy#:_____ Group#_____

Policy Holder:_____ DOB:_____ SSN:_____

The Su Surgical Group

Please check here if this is a worker's compensation claim: ____

Please check here if you are a self-pay: _____

If you have checked either of the two conditions above, please contact our office prior to your appt.

Name of person financially responsible if other than patient:_____

Financial information, authorization for treatment, and privacy notification

Financial Responsibility: I certify that the information provided above regarding my demographics and insurance coverage is correct. I agree to pay any copayment, coinsurances, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that co-payments, co-insurance, deductibles and account balances will be collected at the time of service. If surgery is scheduled, a portion of the deductible may be required before surgery.

Collection Agency Fees: If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that non-payment of my account may result in a discharge from the practice with 30 days notice.

Pharmacy Benefit Management: By signing below, I give consent for William T. Su, MD PA to download medication history for me. This will share any medications paid for by my insurance company into our medical record. Please initial here: _____

Authorization for Medical Billing: I hereby authorize William T. Su, MD PA to submit a claim, and if necessary a copy of my related medical records to my insurance plans for purposes of receiving payment for medical services provided to me or my dependent. I authorize William T. Su, MD PA to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize the payments be made directly to William T. Su, MD PA for all medical insurance benefits which are payable under the terms of my insurance for services provided.

Receipt of Privacy Notice: By signing below I acknowledge that I have the opportunity to review William T. Su, MD PA's Notice of Privacy Practices which provides a detailed description of how my Protected Health Information is used or disclosed. It is available for review at the front desk upon request.

Signature of Patient and/or Guardian (SEAL):_____

Date: _____