

**WESMARK AMBULATORY SURGERY CENTER
PATIENT INFORMATION**

Today's Date: _____ Surgery Date: _____

Patient Name: _____ Date of Birth: _____

Patient sex: _____ Marital Status: _____ Home Phone Number: _____

Home Address: _____

Mailing Address (if different from above):

Employer: _____ Work Number: _____

Cell Phone Number: _____

In the event of an emergency I wish for you to contact:

Emergency Contact Name, Relationship and Phone# _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Patient Relationship to Insured: _____

Insurance Company

Name: _____

Policy #: _____

SECONDARY INSURANCE

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Patient Relationship to Insured: _____

Insurance Company

Name: _____

Policy#: _____

I was notified of the following information prior to the date of my surgery (included in this packet):

- Physician Ownership Disclosure
- Grievance Policy
- Patient Rights and Responsibilities
- Advance Directives

Do you have a Living Will or Health Care Power of Attorney? _____ Yes _____ No

Patient/Responsible Party Signature: _____ Date: _____

**Wesmark Ambulatory Surgery Center
420 W Wesmark Blvd.
Sumter, SC 29150
803-905-5590**

PLACE STICKER HERE

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that apply):

Home Telephone#: _____

Written Communication:

- Permission to leave detailed appointment information O.K to mail to address on file
 Leave call back number only

Work telephone#: _____

Cell phone/other#: _____

- Permission to leave detailed appointment information Permission to leave detailed appointment information
 Leave call back number only Leave call back number only

I give permission to the surgery center and/or my physician to VERBALLY discuss the following information about me: Appointment Information, Financial Information, Pre-op/Post-op Instructions and Pathology Results with the following person(s):

Name: _____ **Relationship to patient:** _____ **Phone#** _____

Name: _____ **Relationship to patient:** _____ **Phone#** _____

Name: _____ **Relationship to patient:** _____ **Phone#** _____

*******By signing this form, I acknowledge receipt of the Wesmark Ambulatory Surgery Center's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Wesmark Ambulatory Surgery Center may use and disclose my (PHI) protected health information. I understand that I have the right to revoke my permission at any time except where the Surgery Center has already made disclosures relying upon this permission request. I understand I must notify the Surgery Center in writing if I want to revoke my permission*******

Patient Signature

Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided here, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Assignment of Benefits Form
 Wesmark Ambulatory Surgery Center

I _____ (**Print Name**) hereby authorize benefits to be assigned to **Wesmark Ambulatory Surgery Center** ("Provider"), for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company with 90 days, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at

420 W Wesmark Blvd. Sumter, SC 29150 for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

 Signature of Patient/Guarantor

 Date

 Signature of Policy Holder (**If different from patient**)

 Date

Please make sure that both lines above are signed by appropriate person