

Petoskey Surgeons, P.C.

Dear Patient,

Welcome to Petoskey Surgeons, P.C. Our training equips us to take care of the surgical needs of virtually everyone – male or female, newly born or advanced in age. Our expertise is in general and vascular surgery includes trauma care, and cancer care.

Our office hours are by appointment Monday through Friday 9:00 am to 5:00 pm. If you should require overnight accommodations in town, several options are available.

Because of the nature of our practice, and the illnesses we treat, occasionally the office schedule may need to be changed with little notice. If your appointment is rescheduled secondary to an emergency, please accept our apologies and know that we will make every effort to reschedule you in a timely manner. We understand that your time is valuable, but unfortunately such unforeseen circumstances do occur. The Centers for Medicare & Medicaid have mandated as part of the American Recovery and Reinvestment Act of 2009, that we ask questions about your heritage and primary language.

HELP US TO HELP YOU MORE EFFICIENTLY

Please let us know if you move, change your insurance, job, or telephone number, and let us know how to reach you in an emergency (work number, cell phone, etc.). Please call to cancel if you are unable to make an appointment. Missed appointments could result in termination of care. If a problem arises, tell us. We will do the best we can to fix it.

PATIENT INFORMATION			
Patient Name	Last:	First	M.I. Date of Birth:
Mailing Address	Street		
Address Line 2	City:	State:	Zip:
Social Security #	X X X - X X - _____ (last 4 digits)	Spouse:	Date of Birth:
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Minor
Race:		Ethnicity/Heritage:	Preferred Language:
PHONE NUMBERS			
Home:		Cell:	Work:
EMERGENCY CONTACT			
Name:		Relationship:	Phone:
PRIMARY CARE PHYSICIAN			
Name:			
Referred By: <input type="checkbox"/> Insurance <input type="checkbox"/> Phone Book <input type="checkbox"/> Friend <input type="checkbox"/> Physician			Name:
RESPONSIBLE PERSON IF DIFFERENT FROM PATIENT – SPOUSE – GUARDIAN			
Name:			Date of Birth:
Mailing Address:			Relationship to Patient:

ASSIGNMENT/AUTHORIZATION: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, BCBSM, and other government sponsored programs, private insurance, and any other health plans to Petoskey Surgeons, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignees to release all information necessary to secure the payment. I also authorize the release of information necessary for my continuing medical care.

Signed: _____ Date: _____

OUR FINANCIAL POLICY

We are dedicated to providing best possible care, and we want you to completely understand our financial policies.

We have made prior arrangements with Medicare, Blue Cross/Blue Shield of Michigan, Priority Health, Co-finity, and ASR to accept assignment of insurance benefits. We bill them and they remit payment directly to us. You are responsible for deductibles, co-pays, and non-covered services at the time of your visit.

Our office will prepare and mail your insurance claim, if you provide us with complete, current insurance information. If you have any questions concerning your bill or our financial policy, please contact our Billing Department.

Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. In other words, if you agree to have your insurance company send payment directly to the doctor. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We suggest you monitor the progress for a claim by retaining your monthly statements and insurance Explanation of Benefits.

There is a \$10.00 administrative fee for form completion.

Medicaid program recipients are required to present a valid Medicaid card at the time of service. We will require payment at the time of service without proper identification. Patients on a Spend-Down Program who have not met their spend-down requirement are expected to pay for care on the day of service.

There is a \$25.00 fee for returned checks. In the event a second check is returned, you will be expected to pay cash for all future care at the time of service.

If you anticipate any financial difficulty in paying your balance, please call to arrange an appropriate payment plan. Delinquent bills are subject to legal action. Please contact us and we will make every reasonable effort to work with you.

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

I have read and understand the above stated financial policies and will adhere to them in all respects.

Signature of patient, parent, or guardian

Please print patient name here

Date