ASSIGNMENT OF BENEFITS / PATIENT INFORMATION

Patient Name _____ Marital Status _____

DOB _____ SSN _____ Gender _____

Email _____

Address _____
(Street) (Apt./Ste) (City) (State) (Zip)

Home Phone _____ Cell _____ Other Phone _____

Allergies/Sensitivities drug (including latex and food) _____

Policy Holder / Parent _____ SSN _____ DOB _____ Phone _____

(Required only if patient is a minor) Parent Driver License # _____ State _____ or Other Photo ID _____

Spouse/Parent Address _____
(Street) (Apt./Ste) (City) (State) (Zip)

Which category best describes your race? ☐ White ☐ Black/ African American ☐ Asian ☐ American Indian/ Alaska Native ☐ Biracial
☐ Native Hawaiian/ Pacific Islander ☐ Other ☐ Unknown ☐ Refuse

Emergency Contact _____ Phone _____ Relationship _____

Name and phone number of the person that will escort you upon discharge from the center _____

Employer _____ Occupation _____ Work Phone _____

Address _____
(Street) (Apt./Ste) (City) (State) (Zip)

Primary Care Physician _____ City _____ Phone _____ FAX _____

To be filled out and asked by Surgery Center Staff only.

If not previously answered: Any travel outside of the U.S. in the past week? ☐ Yes ☐ No If YES, any fever, rash, or productive cough? ☐ Yes ☐ No

CONSENT TO USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION
AUTHORIZATION TO APPEAL, DISPUTE AND ARBITRATE CLAIMS
ASSIGNMENT OF BENEFITS

I, the undersigned, hereafter referred to as "the patient," do hereby authorize Prime Surgical Center of Encino, hereafter referred to as "Provider" to obtain, disclose and/or release my protected health information to others for the purposes of treatment, obtaining payment, or reporting the day-to-day health care operations of the practice. This assignment shall include but is not limited to, all rights available to me pursuant to the State of California.

Assignment of All Rights and Benefits

I, the patient, irrevocably assign the Provider all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, including, without limitation, direct payment to the Provider for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to information, notices and disclosures from any source, (collectively "Rights") that I had, have or may have in the future pursuant to or in connection with any insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Further, in the event that the health carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within five(5) days of receipt of same.

Appointment as Authorized Representative and Right to Sue

I, the patient, hereby designate the Provider as my duly authorized representative in connection with all matters arising from or relating to Services, Rights and Health Coverage, such that the Provider completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedure or entitlement under any Health Coverage.

Agreement to Cooperate

In addition, I, the patient, hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of the Provider as my authorized representative, and I promise to assist and cooperate with the Provider as needed or reasonably requested by the Provider in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by the Provider in connection with the with the Services or relating to any Rights provided under the Health Coverage. I understand that, in the event I do not fulfill any of the above obligations, I will remain personally liable for payment for the Services to the furthest extent of the law.

I, the patient, have been advised and I acknowledge that if an arbitration and/or lawsuit is filed against my insurance company for unfairly processed claims for services provided to me, the attorney will be appointed and chosen by the "provider of the service" in order to collect on all outstanding billed charges for wrongfully denied claims. In consideration, this medical provider does not participate or contract with any health insurers, therefore will not accept reduced or unreasonable benefits warranted by the insurer and will pursue legal actions if necessary to recover outstanding charges.

_____
Patient Signature Date/ Time

PT STICKER LABEL