ASSOCIATED SURGICAL SPECIALISTS, LTD
NEW PATIENT REGISTRATION

DATE:	ACCOUNT# (office use)

NAME LAST	FIRST	MI	SS# - -
STREET ADDRESS	APT #	CITY	STATE	ZIP CODE

BIRTH DATE	SEX	MARITAL STATUS ☐ M ☐ S ☐ D ☐ W	AGE	HOME PHONE ( )

EMPLOYER	WORK PHONE	CELL PHONE
REFERRED BY	PRIMARY CARE PHYSICIAN	PHONE ( )

NEAREST RELATIVE/EMERGENCY CONTACT		HOME PHONE ( )
RELATIONSHIP TO PATIENT	WORK PHONE ( )	CELL PHONE ( )
STREET ADDRESS (if different) CITY	STATE	ZIP CODE

Please complete this portion in its entirety. This is necessary to enable us to file your insurance claim for you. We also request a copy of your insurance cards and/or insurance form with your portion completed.

PRIMARY INSURANCE NAME	POLICY #	GROUP #
INSURED NAME	RELATIONSHIP	SS# - -
INSURANCE ADDRESS STREET CITY	STATE	ZIP CODE

Does this insurance require a referral from your PCP? Yes ☐ No ☐

Does this insurance require Pre-Admission authorization? Yes ☐ No ☐

Does this insurance require a Co-Pay? Yes ☐ No ☐ Amount $ ______

SECONDARY INSURANCE NAME	POLICY #	GROUP #
INSURED NAME	RELATIONSHIP	SS# - -
INSURANCE ADDRESS STREET CITY	STATE	ZIP CODE

Does this insurance require a referral from your PCP? Yes ☐ No ☐

Does this insurance require Pre-Admission authorization? Yes ☐ No ☐

Does this insurance require a Co-Pay? Yes ☐ No ☐ Amount $ ______

DOC 01 02	Office Chart / Acct#

PLEASE REVIEW AND SIGN THE REVERSE SIDE OF THIS FORM

ASSOCIATED SURGICAL SPECIALISTS, LTD
SPI – ASSOCIATED SURGICAL SPECIALISTS
95 ARCH STREET, SUITE 150
AKRON, OHIO 44304
330-564-0728
FAX 330-564-0733
FREDERICK A. SLEZAK, MD JOEL A. PORTER, MD
Diplomates of The American Board of Surgery and The American Board of Colon and Rectal Surgery

STATEMENT OF PATIENT'S RIGHTS

The patient has the right to choose his/her own physician. The patient has the right to choose his/her own medical facility* or hospital*. The patient has the right to privacy, confidentiality of medical records, and confidentiality of any conversations they may have with the employees of the medical facility of their choice. The patient has the right to be free of abuse or harmful situations.

It is the right of the patient to agree or disagree with the type of treatment and or medication with which they are to be treated. It is the patient's responsibility to ask questions about recommended treatment and if agreeing to treatment, following the treatment plan. The patient has the right to refuse treatment after full disclosure regarding such treatment. Refusal of treatment eliminates the physician and staff from responsibility for patient outcomes.

* *the patient's insurance contract may alter the free choice of medical facility or hospital*

SIGNATURE ON FILE

Insurance claim forms are processed by computer. To facilitate this process, your signature is maintained "on file" for this purpose and for use of this office only.

PROFESSIONAL SERVICES ACKNOWLEDGEMENT

All Professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize ASSOCIATED SURGICAL SPECIALISTS, LTD to act as my agent to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any amount not covered by insurance.

MEDICARE RECIPIENT DISCLOSURE

ASSOCIATED SURGICAL SPECIALISTS, LTD participates with the Medicare plan that determines reimbursement for services. I understand that I am responsible for 20% of the MEDICARE ALLOWED CHARGE after my yearly deductible has been met.

UNAUTHORIZED OR NON-COVERED SERVICES

I understand that my insurance policy is a contract between my insurance company and me. I understand that ASSOCIATED SURGICAL SPECIALISTS, LTD is not responsible for claims or charges submitted by other providers. I also understand that it is my responsibility to obtain or bring a referral in advance of my appointment, to pay my co-pay and to obtain any other authorizations that are required by my insurance company. I understand that by not following the parameters set by my insurance company, I may be required to pay for any unauthorized services.

ASSOCIATED SURGICAL SPECIALISTS, LTD reserves the right to limit or deny services to any person who refuses to supply accurate personal or insurance information. Fraudulent medical or insurance information will be considered grounds for termination from this office.

☐ I have read, understand and agree to the consent provisions set forth above.

SIGNATURE	DATE
	/ /