GREG PORTER, M.D. **KEITH MERCER, M.D.** **MATTHEW ZEALEAR, M.D.** **JOHN HAGELE, M.D.**

SIERRA AMBULATORY SURGERY CENTER

PATIENT'S CONFIDENTIAL FILE

❑ Dr. ❑Mr. ❑Mrs. ❑Ms.

Patient Name:_____
Last First Middle Initial

Date of Birth: _____ Age:_____ Sex: M____F ____ Occupation: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Home/Mailing Address: _____
Street Address City State Zip

Social Security #: _____-_____-_____ Employer: _____

Spouse's Name: _____ Date of Birth: _____

Employer: _____ Phone : _____

Referred by Doctor: _____ Family Physician: _____

RACE: Check One
- ❑ American Indian or Alaskan Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Other Race
- ❑ Unknown

ETHNICITY: Check One
- ❑ Hispanic or Latino
- ❑ Non-Hispanic or Non-Latino
- ❑ Unknown

Insurance Information

Primary Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Secondary Insurance Carrier: _____

Name of Insured: _____ Relationship: _____

Please list a contact person in case of emergency: _____ Phone: _____

Medicare Lifetime Insurance Authorization

I request that payment of authorized Medicare and Medi-gap benefits be made to me or on my behalf to Sierra ASC, LLC for any services furnished me by that physician group. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in line 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I authorized the Release of any Medical Information necessary to process my Insurance claims.

Your signature on this form acknowledges that you agree to full financial responsibility for all services provided if, 1) The services are not covered as a benefit under your Health Insurance plan, or 2) Failure to obtain a referral for services from your primary care physician when required by your Health Insurance Plan.

_____ _____
Patient Signature Date