ASHLAND SURGERY CENTER

658 North Main Street
Ashland, OR 97520
541-482-5518

Dear Ashland Surgery Center Patient,

You are scheduled for an upcoming procedure in our facility.

Please fill out the enclosed registration packet and bring it with you to your appointment. Also, please remember to bring your insurance card(s) and photo ID. **If your insurance requires a Co-pay and/or Co-insurance, it will be due at the time of service.**

If you are having cataract surgery and will be receiving a premium lens, these lenses are not covered by insurance and payment will be due at the time of service. If you have any questions regarding your lens, please reach out to your surgery coordinator at Siskiyou Eye Center.

Upon check in for your procedure you will be offered a printed copy of your Patient Bill of Rights and the Ashland Surgery Center's Notice of Privacy Practices. Please review these prior to your procedure on our website www.ashlandsurgerycenter.com.

If you have an Advance Directive, please bring it with you on the day of your procedure. An Advance Directive is a legal document that is prepared in advance of when it is needed that defines critical decisions about a person's health care and indicates the type of medical treatment the person wishes to receive or not receive in the event that he or she is unable to do so. If you would like more information on advance directives, go to Oregon Health Authority : Advance Directive Forms : About the Public Health Division : State of Oregon

Please feel free to contact us with any questions prior to your procedure. All questions regarding your date and arrival time for your procedure and pre-op instructions need to be directed to your doctor's office.

Thank you,

Ashland Surgery Center Staff

ASHLAND SURGERY CENTER

PATIENT REGISTRATION (Please print)

PATIENT INFORMATION

First Name _____Middle _____Last _____

SSN _____ Date of Birth ____/____/____ Age _____ Gender _____

Marital Status (**circle one**) Single / Married / Divorced / Widowed / Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Race: ☐ American Indian or Alaska Native Asian ☐ White
☐ Black or African American ☐ Other
☐ Native Hawaiian or Other Pacific Islander ☐ Declined

Email Address: _____

Mailing Address: Street _____City/ State _____Zip Code _____

Primary Phone # ( ) _____ Home or Cell May we leave a message? ___

Alternate Phone # ( ) _____ Home or Cell May we leave a message? ___

Patient Employment Status: (circle one) Full Time / Part Time / Retired / Not Currently Employed

Employer _____ Phone # ( )_____

EMERGENCY CONTACT INFORMATION

Contact Name _____Relationship _____

Phone # ( ) _____ Alternate Phone # ( ) _____

Can we share information with emergency contact? (Circle one) yes no

Please list name/s of any others we can share information with _____

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INSURANCE INFORMATION

Primary Insurance Company Name _____

ID Number _____ Group Number _____

Subscriber's Name (Policy Holder) _____Relationship to Patient _____

Subscriber's DOB _____Subscriber's SSN _____ Subscriber's Employer _____

Secondary Insurance Company Name _____

ID Number _____ Group Number _____

Subscriber's Name (Policy Holder) _____Relationship to Patient _____

Subscriber's DOB _____Subscriber's SSN _____ Subscriber's Employer _____

Injury information (if applicable)

Date of Injury _____Place of Employment at the time of Injury _____

Work Compensation Insurance/MVA Name _____

Adjuster's Phone # ( ) _____Claim Number _____

Insurance Authorization of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Ashland Surgery Center for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also understand that my secondary insurance will be billed, one time, as a courtesy. If they do not pay within 60 days of being billed the balance will become my responsibility. I also authorize you to release to my insurance company, or their agent, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient (or patient representative) Signature Date

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Ashland Surgery Center for any services furnished me by the facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient (or patient representative) Signature Date

ASHLAND SURGERY CENTER, INC.

FINANCIAL POLICY and PAYMENT AGREEMENT

1. **Policy**. You will be charged once each time you receive care. The total amount owing for treatment received is due and payable in full when treatment is rendered. If we both agree that you will pay for a service in installments, you will pay the remaining balance in accordance with this agreement.

2. **Co-payments**. **Any co-payments required by an insurance company, deductibles, co-insurance, and/or non-covered services must be paid at the time of service.**

3. **Payments Due**. If you have a balance and we both agree that you will pay in installments, as explained above, you will pay the balance in 3 equal monthly installments of at least $100.00, beginning the following month in which the charge is incurred. The payments will continue until the balance is paid in full.

4. **Additional Charges**. If, prior to paying in full any remaining balance, you incur additional charges, they will be due and payable in full when you receive treatment, as explained above. If we both agree that the additional charges may be paid in installments, you must sign a new Financial Policy and Agreement.

5. **Pre-payments**. You may prepay any or all of the unpaid balance without penalty. However, a partial prepayment does not excuse the obligation to make any payment required under this agreement.

6. **Returned Checks**. A fee (currently $35) will be charged for any checks returned by the bank for insufficient funds. ORS 30.701.

7. **Identity Theft Protection**. We will take appropriate measures to verify patient identity and contact information.

8. **Insurance**. Insurance is a contract between you and your insurance company, and we cannot accept the responsibility of collecting your insurance claims or negotiating a settlement on a disputed claim as you are ultimately responsible for your account. As a courtesy to our patients with insurance, we will complete and submit your insurance claim for you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of our charges not covered by insurance.

9. **Worker's Compensation**. We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

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10. **Attorney Fees**. In the event we are required to consult an attorney or commence any legal proceeding for the purpose of interpreting or enforcing any provision of this agreement or to collect any indebtedness owing pursuant to this agreement, we shall be entitled to recover reasonable attorney fees in such proceeding, or any appeal thereof, in addition to the costs and disbursements allowed by law. You will be entitled to recover your reasonable attorney fees from us should you prevail. The amount of the fee shall include an amount estimated by the court as the reasonable costs and fees to be incurred by the prevailing party in collecting any monetary judgment or award or otherwise enforcing any order, judgment, or decree entered in such suit or action.

11. **Notice to Patient/Debtor**. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT YOU SIGN. KEEP THIS AGREEMENT TO PROTECT YOUR LEGAL RIGHTS.

_____ _____

Patient (or patient representative) Signature Date

_____

Print Patient Name