BELLINGHAM SURGERY CENTER PATIENT REGISTRATION

DATE OF SURGERY	SURGEON	(FOR OFFICE USE ONLY) INT/DATE TIME

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SEX	MARITAL STATUS

DATE OF BIRTH	SOCIAL SECURITY NUMBER	HOME PHONE	WORK/CELL PHONE

MAILING ADDRESS	CITY	STATE	ZIP

EMPLOYER NAME OR SCHOOL NAME	FULL TIME STUDENT?	IS THIS SURGERY RELATED TO AN ACCIDENT OR INJURY? EXPLAIN.

L & I CLAIM NUMBER IF WORK RELATED	DATE OF INJURY	EMPLOYER AT TIME OF INJURY

PARENT/RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO PATIENT

HOME PHONE	SOCIAL SECURITY NUMBER	EMPLOYER NAME AND PHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

SUBSCRIBER INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME			SECONDARY INSURANCE CARRIER NAME		
POLICY OR ID NUMBER	GROUP NUMBER		POLICY OR ID NUMBER	GROUP NUMBER	
SUBSRIBER NAME	SUBSCRIBER DOB	HOME PHONE	SUBSCRIBER NAME	SUBSCRIBER DOB	HOME PHONE
SUBSCRIBER SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT		SUBSCRIBER SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	
EMPLOYER	EMPLOYER PHONE #		EMPLOYER	EMPLOYER PHONE #	

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO BELLINGHAM SURGERY CENTER IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER 90 DAYS OLD. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF BELLINGHAM SURGERY CENTER AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPT ACTS OF NEGLIGENCE.

RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE:

Rev 6/04