

Do you have any other insurance? If yes, please list: _____

Are you here for a Workers Comp Accident [] yes [] no Personal Injury [] yes [] no

Are you here for an injury from a motor vehicle accident? [] yes [] no Other injury? [] yes [] no

If yes to either of these questions: **What was your date of injury or accident? _____

How did your injury occur? _____

What is your injury or accident claim number? _____

What is the name/address of your attorney or insurance company for this claim? _____
Phone #: _____

Who referred you to our practice? _____

Primary care physician _____ Phone # _____

If you want any of your current doctors to receive a copy of your office notes/tests from this office, please list them:

We will try to send notes to your referring physician and your primary care physician unless you indicate otherwise.

We may not be able to send notes unless you provide complete, accurate information for your physician(s).

Doctor	Address	Phone#	Fax #

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY BENEFITS: I hereby authorize payment of surgical or medical services, including major medical benefits, directly to GSH Surgery. I understand that I am financially responsible to the hospital and physicians, whether or not covered by this assignment. Should the account be referred to an attorney for collections, the undersigned shall pay reasonable attorney's fees and collection expense. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy, and for payment of services not covered under my policy for those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

MEDICARE/MEDICAID PATIENT CERTIFICATION: I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicare claim. I request that payment of authorized benefits be made on my behalf.

USE AND DISCLOSURE OF HEALTH INFORMATION: I authorize GSH Surgery to disclose any health information (including information related to psychiatry, drug abuse, alcoholism, or HIV testing) for my treatment as well as use of routine Health System operations and payment for services. I further authorize release of health information to other health care providers for continuing care and treatment. I certify that the information I have given with regard to my personal data and my insurance coverage is true and accurate. This assignment of benefits and authorization for release of medical information and treatment are considered in force from the date of signing until revoked in writing. A photocopy of this document is considered as valid as the original.

AUTHORIZATION FOR TREATMENT: I authorize GSH Surgery's physicians and staff to provide medical treatment to the patient named on this form.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Medstar's Health Notice of Privacy Practices.

X _____
Signature of Patient and/or Financially Responsible Party Relationship (If 17 yrs or younger) Date

Patient's Name (Please print) Patient's Date of Birth