Patient Name:_____

PO BOX Number if applicable: _____ **Street Address ONLY if no PO BOX:** _____

City _____

State _____ **Zip code** _____ **Email Address:** _____

Phones: Home_____ Work _____ Cell _____

SOCIAL SECURITY NUMBER: _____

Must have SSN for Ohio Medicaid Patients to check eligibility for the managed care programs

Gender: Male □ Female □ Marital Status: Married □ Single □ Divorced □ Widowed □

DATE OF BIRTH: _____/_____/_____ **Age** _____ ***RACE**: **White □ Black □ Hispanic □ Asian □ Indian □ Other □**

Employer Name:_____ **Address:**_____ **Phone** _____

***Referring Dr**: _____**Primary Care Dr**: _____

Emergency Contact: _____**Relationship: _____ Phone:** _____

Other Contact: _____ **Relationship:** _____ **Phone:**_____

Spouse's Name (If Applicable) _____ **Date of Birth** _____ **SSN**_____

Spouse's Employer: _____ Work Phone: _____

BILLING INFORMATION

RESPONSIBLE PARTY (If other than patient) _____**Date of Birth**_____ **SSN**_____

PO BOX:_____ Or Address if no PO BOX_____ Phone _____

Relationship to patient if patient is a minor (**Circle One**): Spouse Child Step Child Other _____

Employer _____ Work Phone _____ Address _____

I assign all medical and/or surgical benefits from all insurance companies that I am involved with to Surgical Specialists of BG. I authorize the staff to release any information necessary to secure the proper payment. I authorize the release of any medical and/or billing information requested by a referred to and/or from physician or any other third party administrator (insurance company, medical facility, attorney, collection agency) at my, or my physician/staff request. I am aware that I am responsible for copayments at each visit on the date of each visit.
I also agree to pay all collection agency fees should my account be turned over to the collection agency.

I AUTHORIZE SURGICAL SPECIALISTS OF BOWLING GREEN, LLC
TO FILE MY INSURANCE CLAIMS AND I AUTHORIZE ASSIGNMENT OF BENEFITS TO SURGICAL SPECIALISTS OF BOWLING GREEN
I HAVE RECEIVED A COPY OF BOWLING GREEN SURGICAL SPECIALISTS FINANCIAL & PRIVACY POLICY
I DO AUTHORIZE TREATMENT AS RECOMMENDED
I AM SIGNING BELOW FOR ALL OF THE ABOVE STATEMENTS

SIGN→ **SIGNATURE ON FILE:**_____ **DATE:**_____

SIGN→ **RESPONSIBLE PARTY SIGNATURE IF PATIENT IS A MINOR:** _____ **DATE:**_____

PATIENT CONSENT FORM FOR SURGICAL SPECIALISTS OF BOWLING GREEN

FILL HERE

I, (Please Print) PATIENTS NAME _____

PATIENTS DATE OF BIRTH _____

Give permission to the following persons to receive any medical or financial information from the office of Surgical Specialists of Bowling Green, LLC, Michael Bielefeld, MD/Todd Tamlyn, MD. This would include the staff of the physicians and hospital personnel if requested.

This is part of this offices HIPAA compliance

* SPOUSE

NAME OF SPOUSE IF YOU WANT HIM/HER TO HAVE ACCESS TO YOUR MEDICAL RECORDS

LIST SPOUSE NAME HERE:_____

Others- Anyone we are allowed to give information or prescriptions to (Example-Children, Neighbor, Relative, Friend)

SIGN →

SIGNATURE TO RELEASE INFORMATION LISTED BELOW : _____ DATE: _____

CHECK BELOW FOR RELEASE OF INFORMATION TO THE FOLLOWING COMPANIES:	
FMLA, SHORT/LONG TERM DISABILITY,	**CHECK IF DESIRED** ☐
AUTO INSURANCE AND WORKMANS COMPENSATION COMPANES,	**CHECK IF DESIRED** ☐

We will leave a message for you on your answering machine/voice mail regarding a call to the office if needed or other general information unless otherwise advised by you. No test results or medical/financial information will be left in this manner

SIGN HERE →

***SIGNATURE FOR HIPAA: _____ * DATE _____**