BELLINGHAM AMBULATORY SURGERY CENTER PATIENT REGISTRATION

Surgery Date	Surgeon	(For office use only) INT/Date Time

PATIENT INFORMATION

Last Name	First Name	MI	Sex	Marital status
Birth date	Social Security Number	Home Phone	Cell/work Phone	
Best time to call?	Which number? Home/cell/work?			
Mailing Address	City	State	Zip	
Employer Name or School Name	Employer at time of injury			
L&I Claim # if work related	Injury date	Is surgery related to a work injury? Explain		
Email (not for solicitation)				

RESPONSIBLE PARTY ☐ SELF ☐ PARENT/GUARDIAN INFORMATION

Last Name	First Name	MI	Birth Date	Relationship to Pt
Home/Cell Phone	Social Security Number	Employer name & Phone		
Mailing address	City	State	Zip	

SUBSCRIBER INSURANCE INFORMATION

Primary Insurance Carrier Name		Secondary Insurance Carrier Name	
Policy or ID #	Group #	Policy or ID #	Group #
Subscriber Name	Subscriber DOB	Subscriber Name	Subscriber DOB
Relationship to patient		Relationship to patient	

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

I hereby assign all Medical Benefits to which I am entitled to Bellingham Ambulatory Surgery Center in the even they file insurance claim 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 associate 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 hereby do consent to such treatment by the authorized personnel of Bellingham Ambulatory 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 as acts of negligence.

Responsible Party Signature

Date

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