

(For Office Use Only)

PHYSICIAN \_\_\_\_\_

CHART # \_\_\_\_\_

DATE \_\_\_\_\_

EMPLOYEE'S INITIALS \_\_\_\_\_



Two Richland Medical Park, Suite 306  
Columbia, South Carolina 29203-7868

UNIVERSITY SPECIALTY CLINICS®  
SURGERY

Telephone: (803) 545-5800

PATIENT INFORMATION

PATIENT'S NAME (LAST) (FIRST) (MIDDLE)			DATE OF BIRTH		
			MO.	DAY	YR.
PHYSICAL ADDRESS (NUMBER) (STREET)		(CITY)	(STATE)	(ZIP CODE)	
MAILING ADDRESS			E-MAIL ADDRESS		MOBILE TELEPHONE
PATIENT'S SOCIAL SECURITY NUMBER		PATIENT'S SEX	PATIENT'S MARITAL STATUS		HOME TELEPHONE
PATIENT'S OCCUPATION		PATIENT'S EMPLOYER		HOW LONG EMPLOYED?	WORK TELEPHONE
EMPLOYER'S ADDRESS (NUMBER) (STREET)		(CITY)	(STATE)	(ZIP CODE)	
PARENT'S OR SPOUSE'S NAME			PARENT'S OR SPOUSE'S SOCIAL SECURITY NUMBER		
PARENT'S OR SPOUSE'S EMPLOYER		ADDRESS (CITY) (STATE) (ZIP CODE)	WORK TELEPHONE		
FAMILY PHYSICIAN		ADDRESS (CITY) (STATE) (ZIP CODE)	OFFICE TELEPHONE		
WHO REFERRED YOU TO OUR OFFICE?		ADDRESS (CITY) (STATE) (ZIP CODE)			

EMERGENCY CONTACT PERSON ADDRESS AND PHONE NUMBER OF THE CLOSEST RELATIVE NOT LIVING WITH THE PATIENT:

PREFERRED PHARMACY (ADDRESS AND PHONE NUMBER)

-ALL OFFICE EXAMINATION FEES ARE DUE FOR PAYMENT ON DATE OF TREATMENT-

INSURANCE INFORMATION-INCLUDE MEDICARE OR MEDICAID

IS THIS A WORKMAN'S COMP CLAIM? \_\_\_\_\_ ARE YOU COVERED BY CHAMPUS? \_\_\_\_\_

#1 NAME OF INSURANCE CO:		GROUP #:		or PRIVATE #	
NAME OF INSURED	DATE OF BIRTH / /	RELATION TO PATIENT	CERTIFICATE / SOCIAL SECURITY NUMBER		
IF GROUP, EMPLOYER'S NAME			GROUP OR PRIVATE POLICY NUMBER		
ADDRESS TO MAIL INSURANCE CLAIMS					

INSURANCE PRECERTIFICATION REQUIRED? \_\_\_\_\_ PRECERTIFICATION PHONE # \_\_\_\_\_

#2 NAME OF INSURANCE CO:		GROUP #:		or PRIVATE #	
NAME OF INSURED	DATE OF BIRTH / /	RELATION TO PATIENT	CERTIFICATE / SOCIAL SECURITY NUMBER		
IF GROUP, EMPLOYER'S NAME			GROUP OR PRIVATE POLICY NUMBER		
ADDRESS TO MAIL INSURANCE CLAIMS					

INSURANCE PRECERTIFICATION REQUIRED? \_\_\_\_\_ PRECERTIFICATION PHONE # \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/SUPPLIER TO RELEASE INFORMATION:** I request that payment of authorized Medicare/Third Party Payer benefits be paid on my behalf to University Specialty Clinics® Surgery for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents and/or Third Party Payers any information needed to determine benefits and/or to other providers for further treatment.

_____ SIGNED / INSURED OR AUTHORIZED PERSON	
RELATIONSHIP TO PATIENT	DATE

(PLEASE READ OUR FINANCIAL AND INSURANCE POLICY ON REVERSE SIDE OF FORM)

**UNIVERSITY SPECIALTY CLINICS®  
SURGERY**

**FINANCIAL POLICY**

Credit is extended to those patients who need it. However, our policy is

**CREDIT ARRANGEMENTS MUST BE MADE BEFORE SERVICES RENDERED**

By making arrangements in advance for time payment and keeping your account current, you can avoid the risk of future credit problems with this office.

**INSURANCE**

Payment for office visits and services is expected at the time of service. Co-payments and deductibles will be collected at the time of check-in. We accept cash, personal checks, and most major credit cards for office services. Financial counseling services are available. If you have a problem, please speak to the receptionist and he/she will direct you to our patient accounts representative.

Our patient accounts department will file insurance claims on your behalf for major surgical procedures; however, it is essential that you bring your insurance cards and other pertinent information with you such as insurance preauthorizations, etc. We ask that you keep us informed of any change in your name, address, telephone number, or insurance coverage.

We usually require a deposit for certain procedures considered elective (non-life threatening conditions). Most insurance carriers now require prior approval for payment of services. Pre-authorization for services is not a guarantee of payment. Please be familiar with the requirements of your policy before asking us to schedule your operative procedure. We will allow 45 days grace period for your insurance company to process and pay assigned claims. Payment in full is expected by you after the grace period has elapsed. We do accept assignment for Medicare claims. The patient is responsible for deductible and coinsurance portions as provided by federal law. Any balance resulting from underpayment by your insurance company must be paid by you.

Please note that you can pay your bill online by visiting <http://surgery.med.sc.edu>. Just click "Pay My Bill Online" from the left side menu bar and you will be directed to complete a secure personal account.

Questions regarding insurance claims or monthly statements should be directed to our patient accounts representatives at (803) 256-2657.

**COSMETIC SERVICES**

Cosmetic surgical services are payable 15 business days prior to your scheduled surgery date. We do not accept credit card payments for these surgical procedures. You may pay for your procedure by cash, personal check, cashiers check, or certified money order.

**I have read the above financial policy of the Univeristy Specialty Clinics® - Surgery and have had any questions answered to my satisfaction and understanding:**

SIGNED/INSURED OR AUTHORIZED PERSON

RELATIONSHIP TO PATIENT

DATE