PSCF PHYSICIANS SURGERY CENTER of Frederick

PATIENT REGISTRATION FORM

Name: _____ Today's Date: _____
Address: _____
Cell Ph#: _____ Home Ph#: _____ Work Ph#: _____
SS#: _____ - ____ - _____ Birth Date: _____/_____/_____ Marital Status: ○S ○M ○D ◉W
Employer / School: _____
Address: _____
Occupation: _____ Full Time Part Time Student
Who will be staying at the center with you today? _____
Relationship: _____ Phone#: _____

Who will be responsible for your account? Self / Spouse / Father / Mother / Other
Name of responsible party : _____ SS#: ____ - ___ - _____ Ph#: _____
Address: _____

Primary Insurance:	**Secondary Insurance:**
Insurance Co Name: _____	Insurance Co Name: _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder's Birth Date: _____	Policy Holder's Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policy Holder's Employer:_____	Policy Holder's Employer:_____
Identification#: _____	Identification#: _____
Policy/Group#: _____	Policy/Group#: _____

For Worker's Comp / Auto / PIP Insurance ONLY: Date of Accident/Injury: _____
Claim#: _____ Adjuster's Name: _____ Ph#: _____

Physicians Surgery Center of Frederick is committed to providing the highest level of patient care. To achieve this objective, we ask our patients or their caretakers to complete a brief patient satisfaction survey after their surgery.

To better serve you, we have automated this process. Within 48 hours of your discharge from our facility, you will receive an email providing you with a link to our survey. The survey is performed online via a secure Internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey will be entered into a monthly drawing for a $100.00 gift certificate to Amazon.com.

If you wish to participate, Please provide your email address in the space below:
_____. If you do not have an email, please let us know and we will provide you with a paper version to complete and return to us.

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

Assignment of Benefits: I hereby authorize Physicians Surgery Center of Frederick to release and/or obtain any information necessary to process insurance claims for services rendered to me or my dependent. I also authorize benefits to be paid directly to Physicians Surgery Center of Frederick. I understand that I will be responsible for copayments, deductibles, and any balances remaining after insurance has paid. By signing below, I attest all information provided is correct.

Signature: _____ Date:_____

Anesthesia services are billed separately by US Anesthesia Partners. Pathology services are billed separately by HCT Pathology Services, Frederick Memorial Hospital or Pathology Service as directed by Surgeon.