RODNEY C. BIGGS, MD, PC
GENERAL SURGERY

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Information and Authorization Sheet

Patient Information

Last Name_____ First Name_____ MI____ Nickname_____ DOB_____
Mailing Address_____ City_____ State_____ Zip_____
Physical Address_____ City _____ State _____ Zip _____
Home Phone_____ Cell Phone_____ Work Phone_____
SS#_____ Marital Status_____ Race_____ Language_____
Ethnicity ☐ Hispanic/Latin ☐ NOT Hispanic/Latin Preference on Notification's ☐ Voice Message ☐ Text
Patient's Employer_____ Phone_____ Occupation_____
Employer Address_____ City_____ State_____ Zip_____
Primary Care Physician_____ Referring Provider if applicable_____
Emergency Contact_____ Phone_____
Email_____ What Pharmacy Do You Use?_____

Spouse Information (Please complete) / (If under 18, please complete as parent/guardian)

Last Name_____ First Name_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
SS#_____ Home Phone_____ Cell Phone_____ Work Phone_____
Employer_____ Employer Address_____

Insurance Information

Insurance Company_____ Subscriber's Name_____
Subscriber Number_____ Subscriber's Date of Birth_____ Relationship to Patient_____
Secondary Insurance Company_____ Subscriber's Name_____
Subscriber Number_____ Subscriber's Date of Birth_____ Relationship to Patient_____

Injuries

Were You Injured on the Job? ☐Yes ☐No Have you informed your employer? ☐Yes ☐No ☐N/A Place of Injury:_____
Were You Injured in a Motor Vehicle Accident? ☐Yes ☐No Other Accident:_____ Date of Injury:_____
Responsible Insurance Carrier:_____ Policy #_____

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize and direct any holder of medical information regarding my medical history, symptoms, treatment, examination results or diagnosis to release ALL information to Rodney C Biggs, PC. I also give my permission for records FROM any physician, hospital or any other medical provider be released BY Rodney C Biggs, PC as pertains to their care of me. This authorization shall remain in full force and effect until revoked in writing by myself. A photocopy of this authorization shall be considered as valid as the original.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Rodney C Biggs, PC to release any information needed to my insurance carriers to determine benefits payable for related services. I hereby assign to Rodney C Biggs, PC all payments for medical/surgical services rendered to me and/or my dependents.

In consideration of professional services rendered to the above patient, I/we agree to pay your customary charge for these services in full at the time of service, unless other arrangements are made with the Doctor or the office manager. I/we authorize the Doctor to receive assignment of Insurance payments. If the customary charges are more than the benefits allowed under any Insurance plan that I/we have, I/we agree to pay the difference.

Patient's/Guardian's Signature_____ Date_____

Please complete both sides of this form including the financial policy. Thank you.

FINANCIAL POLICY

BASIC POLICY: Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. ***Copayments and deductibles are due at the time of service.*** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
WELFARE PATIENTS: All welfare patients must provide a current, valid sticker before being seen.
SURGERY FEES: All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.
YEARLY HEALTH CHECKS: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.
MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please check: I have paid my insurance deductible for the calendar year □Yes □No □Don't know

CREDIT TERMS EFFECTIVE JANUARY 1, 2008

- Monthly payments are required on all accounts. Payments may be made by cash, check or credit card. Balances remaining unpaid after 90 days are subject to a FINANCE CHARGE at the periodic rate of 1.5% per month, which is an ANNUAL PERCENTAGE RATE of 18%. We compute the FINANCE CHARGE by applying the periodic rate to the adjusted balance of your account. That balance is determined by taking the balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle.
- To avoid FINANCE CHARGE, pay the "Over 90 Days" balance shown on your billing statement by the 25th day of the month immediately following the billing statement date.
- To make arrangements for minimum monthly payments, please ask to see our Business Manager – AJ Mansheim.

I have read, understood, and agreed to the above financial policy for payment of professional fees.
I have been notified of the Credit Terms and I authorize any holder of information regarding the financial status or collection of my account, **including employment verification**, to release said information to Rodney C Biggs, MD, PC :

Patient's/Guardian's Signature_____ Date_____

** Medicare Patients Only**
PATIENT'S MEDIGAP AUTHORIZATION

Name_____ Medicare#_____

Medigap (2nd Insurance) Name_____

Medigap (2nd Insurance) Policy#_____

I request that payment of authorized Medigap benefits be made on my behalf to Rodney C. Biggs, MD, PC for any services furnished me. I authorize any holder of medical information about me to release to _____(Name of Medigap Insurer) any information needed to determine these benefits.

Patient's Signature_____ Date_____

Please complete both sides of this form including the personal information. Thank you.