Surgical Center of the Rockies

Welcome to Surgical Center of the Rockies!

Please print **ALL** information requested. This form must be complete in order for us to bill your insurance properly.

Name: _____
Last First Middle Initial

Sex: ☐M ☐F **Date of Birth:** ____/_____/_____ **Age:** _____ **Marital Status** ☐S ☐M ☐D ☐W ☐Sep
SSN: _____ **Driver's License #:** _____ State:_____
Home Address: _____ **City, State, Zip:** _____
Home Phone: _____ **Is this your first visit to our surgery center?** ☐Yes ☐No
Employer: _____ **Business Phone:** _____

Insurance Information

Primary Cardholder's Information (If the Cardholder is also the patient check the same as above box and move onto the next section.)

☐Primary Cardholder is also the patient/same as above.

Name: _____
Last First Middle Initial

Date of Birth: ____/_____/_____ **SSN:** _____ **Relation to the patient:** _____
Address: _____ **City, State, Zip:** _____
Home Phone: _____ **Employer:** _____
Business Address: _____ **City, State, Zip:** _____
Business Phone: _____

1. **Is the patient's injury/illness due to a work accident?** ☐ Yes ☐ No
2. **Is the patient's injury/Illness due to a car accident?** ☐ Yes ☐ No
3. **Will your ride wait for you at the surgery center?** ☐ Yes **~OR~ Pick you up after surgery?** ☐ Yes
4. **Name and telephone number of the person providing your ride home:**
   Name: _____ Telephone: _____
5. **Emergency Contact:**
   Name: _____ Telephone:_____
   Relationship to the Patient: _____
6. **Has your surgeon provided you with an informed consent for this surgery?** ☐ Yes ☐ No

I hereby certify that all of the above information is correct:

X_____
Patient or Guardian Date

Please complete and return this form to us on the day of your surgery.
You must bring your ID and all relevant insurance cards with you, on the day of your surgery.
If you have any questions about this form, please ask one of our employees at the Admissions Desk

Surgical Center of the Rockies

Permission to Speak to…

This section is to be completed by Patient/Parent/Guardian/Personal Representative

Surgical Center of the Rockies may speak to the following individuals regarding my healthcare…

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Surgical Center of the Rockies has my permission to call and leave a message regarding my healthcare at the following numbers…

Home: ☐ Yes #_____ ☐ No

Work: ☐ Yes #_____ ☐ No

Cell Phone: ☐ Yes #_____ ☐ No

Other: _____ ☐ Yes #_____ ☐ No

My signature below indicates I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Surgical Center of the Rockies may use and/or disclose, to the persons/phone numbers listed on this form, my protected health information.

I understand that I may revoke this authorization at any time by given written notice to Surgical Center of the Rockies. I further understand that revocation of this authorization will not affect any action you took in reference to disclosing my protected health information before you received my written revocation notice.

_____ _____
Signature Date

_____
Printed Name

Revocation of permission to speak to…

I hereby revoke my permission to release my protective health information to the above individuals and phone numbers.

_____ _____
Signature Date