NorthStar Surgery Specialists, P.A.
2217 Park Bend Drive, Suite 220
Austin, TX 78758
Phone: 512-491-6542 | Fax: 512-491-0161

Patient Registration Form

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's last name: First: Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email Address:			Birth date: / /	Age: Sex: ❑ M ❑ F
Street address:	Social Security no.:		Home phone no.:	
City:	State:	ZIP Code:	Cell phone no.:	
Occupation:	Employer:		Employer phone no.:	

Preferred Language: ❑ English ❑ Spanish ❑ Other:

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Genderqueer
❑ Other _____ ❑ Decline to Answer

Sexuality: ❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Something else : _____ ❑ Don't Know ❑ Decline

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:				
Policy holders name:	Policy holders S.S. #:	Birth date: / /	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Employer:	Employer address:		Employer phone #: ( )	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

I, the undersigned, authorize payment of medical benefits to ***Northstar Surgery Specialists, P.A.*** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided by me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient/Guardian signature **Date**

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Additional Information

1. **In case of an emergency**, please notify:

   Name: _____ Phone Number: _____

   Relationship to patient: _____

   May we inform this person of confidential information? YES NO

   Name: _____ Phone Number: _____

   Relationship to patient: _____

   May we inform this person of confidential information? YES NO

2. Can confidential messages be left on your:

   Home telephone answering machine: ☐ Yes ☐ No
   Cell phone voicemail: ☐ Yes ☐ No
   Work voicemail: ☐ Yes ☐ No
   Personal Email ☐ Yes ☐ No

3. Do you have a LIVING WILL? ☐ Yes ☐ No

4. Do you have a Medical POWER OF ATTORNEY? ☐ Yes ☐ No

   If yes, Name _____ Number _____

5. **Pharmacy Information:**

   Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

   Pharmacy Address: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & CANCELLATION POLICY

I have reviewed the Notice of Privacy Practices of NorthStar Surgery Specialists, P.A., which explains in plain language how my protected health information (PHI) will be used and disclosed, my individual rights, and the practice's legal duties with respect to my PHI. I understand that I am entitled to receive a copy of this information upon request.

I also acknowledge the following cancellation/no show policy: **New patients that no show to a scheduled appointment are subject to a $50 no show charge. Also, established/post-operative patients are subject to a cancellation/reschedule/no show charge of $50 if a 24-hour notice is not given. A 7-day notice must be given to cancel/reschedule surgery. If a 7-day notice is not given, you are subject to a $250 cancellation fee.**

Signature _____ Date _____

Release of Medical Records

I am requesting that the medical information be transferred to **NorthStar Surgery Specialists, PA.**

I understand that the information in my or my child's health record may include information relating to STD, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature _____ Date _____

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Credit Card on File Policy

Please complete this form in its entirety. This form serves as confirmation that you are aware that NorthStar Surgery Specialists P.A. has a policy that requires each patient to follow a payment plan with a credit card on file.

I, _____hereby consent to follow the payment agreement given below with strict abidance. Should I have any difficulty, I fully accept it as my responsibility to report this matter to NorthStar Surgery Specialists before my next payment, to allow for alternate arrangements to be made.

This policy is in effect due to the rise in patient deductibles and patient responsibility due to the change in health insurance policies and guidelines. If you have any questions about your coverage, please contact your insurance company on the number listed on the back of your insurance card.

If surgery is required, a cost estimation will be provided to you prior to surgery **upon request.**

The benefit of this form is that no cost will be collected up front prior to surgery. By signing below, this allows us to set you up on a payment plan of $100/month for all charges incurred from office visits and operations. If you decline to put your card on file, you will be responsible for paying your amount due in full PRIOR TO SERVICES, unless alternate payment arrangements have been agreed upon by the billing administrator of NorthStar Surgery Specialists, P.A.

Patient Name (Please Print):_____
Date of Birth: _____ Email for notification: _____

YOU WILL RECEIVE A CONFIRMATION EMAIL PRIOR TO ANYTHING BEING CHARGED ON YOUR CREDIT CARD

The below credit card will be used for any charge incurred from office visits/ operations. This card will be set up for a payment plan of $100/month after insurance's final determination unless otherwise specified (defaults to the 1st day of every month unless otherwise specified).

Please use Credit Card #:_____ EXP:_____

CW: _____Billing Zip Code: _____on the _____day of every month.

Signature: _____Date: _____

OR

I decline to put my card on file, with the understanding that will be responsible for payment in FULL of any balance prior to any procedure performed/office visit.

Signature: _____Date:_____

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Statement of Billing Practices

I acknowledge that I have had an opportunity to read and understand the billing practices outlined below. I have had the opportunity to ask any questions I may have.
If I have questions, I understand that it is the patient's responsibility to obtain answers to their questions.

Signature Date

Patients will receive a total of 3 bills via mail to the address given on the patient registration form. If no payment is received, the patient is subject to consideration for our external collection agency.

If an email is on file, we will attempt to send you a courtesy email when your account is at risk of being referred to our collection agency. We ask that upon receipt, you reach out to our office within 5 business days to arrange payment.

As a final attempt, we will attempt to reach out to you via phone once to the phone number listed on file, this FINAL attempt will be made 5 business days prior to your account being referred to collections.

We ask that payment be remitted to our office within 30 days of receipt of the statement.

We offer courtesy flexible payment plans for balances due to help patients with the amounts due.

We also offer online payments for your convenience on our website:
WWW.NORTHSTARSURGERY.COM

Feel free to give us a call to discuss your options at:
512-491-6542