



ADVANCED SPECIALTY CARE

2084 N.E. PROFESSIONAL COURT
BEND, OR 97701 ■ (541) 322-5753

236 N.W. KINGWOOD AVE. ■ SUITE A
REDMOND, OR 97756 ■ (541) 548-7743
WWW.ADVANCEDSPECIALTYCARE.COM

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Work Phone: (____) _____
 Employer: _____ Emergency Phone: (____) _____
 Social Security Number: _____ - _____ - _____ Date of Birth: _____

Please check one (all 3 sections):

Gender: Male
 Female
 Ethnicity: Hispanic / Latino
 Non-Hispanic/Non-Latino
 Abstain from answering
 Unknown

Race: American Indian / Alaska Native
 Asian
 Black / African-American
 Hawaiian / Pacific Islander
 White
 Abstain from answering
 Unknown
 Other

Do you have an Advanced Directive? Yes No
 Would you like one? Yes No *(If yes, please ask the registration clerk for a copy.)*

Primary Physician: _____ Referring Physician: _____
 Driver's License or State Issued ID number: _____

RESPONSIBLE PARTY (if different than patient)

Last Name: _____ First Name: _____ Middle: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Work Phone: (____) _____
 Employer: _____
 Social Security Number: _____ - _____ - _____ Date of Birth: _____

Gender: Male Female Relationship to Patient: _____
 Would you like to receive an ASC newsletter via email? Yes No

Email: _____@_____._____

Can we leave a detailed message on answering machine or voice mail?
 (Please initial one) Yes _____ No _____

***** Payment in full is required at the time of service for all patients
 without proof of active insurance. _____ initials *****

OVER →

Primary Insurance Information

Insurance Company Name: _____ ID # _____
Group Number: _____ Effective Date: _____
Insured Member: _____ Relationship to Patient: _____
Required Co-Pay \$ _____ (Due at time of service)

Secondary Insurance Information

Insurance Company Name: _____ ID # _____
Group Number: _____ Effective Date: _____
Insured Member: _____ Relationship to Patient: _____

If you are not the Owner of either of the above policies please complete this section with owner information:

Last Name _____ First Name _____ Middle _____
Address _____ City _____ State _____ Zip _____
Phone (____) _____ Work Phone (____) _____
Social Security Number _____ - _____ - _____ Date of Birth: _____

AUTHORIZATIONS

I authorize Advanced Specialty Care to bill my insurance company for services provided to me. I authorize Advanced Specialty Care to release information acquired during the course of treatment to my insurance carriers.

I authorize Advanced Specialty Care to provide care for myself, minors and any other individuals covered under this account. I accept full responsibility for payment thereof.

I hereby assign to Advanced Specialty Care all insurance benefits due me to the full extent of my financial obligation to said provider.

I understand my insurance coverage is a contractual relationship between my insurance company and myself and agree to accept financial responsibility for all charges incurred. All unpaid charges remaining after 30 days from the date of the billing statement will be subject to a service charge of 1.5 percent per month, plus collection costs and attorney fees.

I understand that a 24 hour cancellation notice for appointments is required. A service fee of \$100.00 for any un-cancelled appointments and \$200.00 or any un-cancelled surgeries may apply to cancellations not made within 24 hours.

I have received a copy of the Notice of Privacy Practice policy and the Financial Policy.

Patient/Responsible Party: _____ **Date:** _____

Witness: _____ **Date:** _____