**CENTER for SPECIALIZED SURGERY of SANTA BARBARA**
**2927 De La Vina Street**
**Santa Barbara, CA 93105**

# REGISTRATION FORM / FINANCIAL AGREEMENT

| PATIENT INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| **Last Name** | | **First Name** | | **M.I.** | **Social Security Number** | |
| **M/F** | **DOB** | **Home #** | **Cell #** | **Ride Name / Phone #** | | |
| **Address** | **Street** | | **City** | **County** | **State** | **ZIP** |
| **Email:** | | | | | | |

| BILLING INFORMATION | | | | | |
|---|---|---|---|---|---|
| **PRIVATE INSURANCE ONLY:** | | | | | |
| **Primary Ins Co Name / Name of Insured** | | | **Secondary Ins Co Name / Name of Insured** | | |
| **Insured's ID #** | **Group #** | **Insured's DOB** | **ID #** | **Group #** | **Insured's DOB** |
| **Insured Employer and Phone #** | | | **Insured Employer and Phone #** | | |
| **FOR WORK COMP ONLY:** | | | | | |
| **Name of Employer** | **Employer City:** | | **Work #:** | | **Date of Injury** |
| **FOR PERSONAL INJURY ONLY:** | | | | | |
| **Name of Law Firm:** | **Address:** | | **Phone #:** | | |

| Responsible Party | | |
|---|---|---|
| **If the patient is a minor, please provide the following information for the responsible party :** | | |
| **Name of local friend or Relative** | **Relationship to Patient** | **Phone #** |

**ASSIGNMENT OF BENEFITS**

I am the above Named Insured with the Insurance Company(S) listed above. I hereby authorize any benefits due to me under my insurance policy(s) to be paid according to this Assignment. I assign, transfer and request that any insurance payment related to the service(s) that are receive today is to be paid directly to the provider of service, be it facility, physician, anesthesiologist, hospital, pathologist and/or other supplier. A photostatic copy of this agreement shall be considered effective and valid as the original.

**FINANCIAL AGREEMENT / BILLING AUTHORIZATION**

I INDIVIDUALLY AGREE TO PAY THE ACCOUNT OF CENTER FOR SPECIALIZED SURGERY OF SANTA BARBARA ("CSS") IN ACCORDANCE WITH ITS REGULAR RATES AND TERMS as consideration for the services rendered to me. I authorize direct payment of any insurance benefits to CENTER FOR SPECIALIZED SURGERY OF SANTA BARBARA that are otherwise payable to me for this admission at a rate not to exceed CSS' regular charges. Should my account be referred to an attorney or collection agency for collection, I agree to pay all reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days) shall accrue interest at the legal rate. I understand that I am financially responsible for any charges not covered by my Insurance Company(s). After 60 days from the date of surgery, the total balances will be considered due and payable. I agree to notify CSS of any changes in my health care coverage. I understand that exact charges and insurance benefits cannot be determined until the services have been rendered and the insurance company processes my claim. I understand that the surgeon, co-surgeon, anesthesiologist, pathologist, laboratory or equipment provider selected by my surgeon, are separate from the surgery center and will receive separate bills for these services.

I understand that the CENTER FOR SPECIALIZED SURGERY OF SANTA BARBARA shall have the right at any time to refuse to admit me or my dependent(s) or to provide medical care or treatment for me or my dependent(s). I authorize the release of any medical or other information needed to provide services to me and to determine benefits for all services rendered.

I certify that I am the patient or am duly authorized by the patient as patient's general agent to execute this document and accept its terms.

| Signed: | Date: | Witness: |
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