RODNEY C. BIGGS, MD, PC
GENERAL SURGERY

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 Notifications ☐ 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?_____
I give my consent for Rodney C. Biggs to review my pharmaceutical history. Yes ☐ NO ☐

Spouse/Parent or Guardian information (please complete)

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

Insurance Information (If card is not provided)

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

SELF-PAY/PATIENT BALANCE: All self-pay patients are required to pay original consultation in full. Charges start at $222 and increase depending on level of care. If the patient schedules surgery, we require 20% of all planned charges paid 24 hours prior to surgery. We would also require a signed financial agreement for the remaining balance. The Patient/Guarantor is responsible for making financial arrangements with our office. Failure to do so will result in cancellation of office visits and/or surgery.

FOR PATIENTS WITH INSURANCE/MEDICARE/MEDICAID: All patients must provide a current and valid insurance card before being seen. We bill most insurance carriers if proper paperwork/information is provided to us. We will also bill most secondary insurance companies. **Copayments and deductibles are due at the time of service**. If an insurance carrier has not paid within 60 days of claim submission, all professional fees are due and payable in full by the Patient/Guarantor. All balances after insurance payment are expected to be paid in full. If no attempt to pay has been made within 90 days, accounts will automatically be turned over to collections with a third party.

INSURANCE NOTIFICATION: We will contact the patient's insurance company prior to surgery to obtain benefits and verify requirements of pre-certification/pre-authorization. This does not guarantee payment from insurance companies. If the Patient/Guarantor's insurance company does not pay, the Patient/Guarantor is responsible. Insurance is a private contract between the Patient/Guarantor and the insurance company. The Patient/Guarantor is ultimately responsible for verifying coverage with the insurance company. We will do our best to assist you in this process.

NON-COVERED SERVICES: Any care not covered by the patient's insurance plan will require payment in full at the time services are provided or upon notice of insurance claim denial; unless an approved payment arrangement is made.

CREDIT/COLLECTION TERMS: Monthly payments are required on all accounts. Payments may be made by cash, check, debit/credit card or papaya. 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%. To avoid FINANCE CHARGE, pay the "Over 90 Days" balance shown on your billing statement. Any accounts sent to Collections will include a fee of 25% of all remaining charges turned over. This amount will be added to the account balance. If any court, legal or attorney fees are acquired to pursue unpaid balances; this will be the Patient/Guarantor responsibility. These fees will be added to the remaining account balance. By signing this policy, 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 for collection purposes.

CHECKS: All returned checks will be subject to a $30 fee, and up to three (3) times the face value of the check or a minimum of $100.00, if not paid within 30 days as provided for in W.S. 1-1-115(b).

EXPLANATION OF FEES: An explanation of fees is available upon request for Patient/Guarantor. This is a detailed breakdown of all factors that may contribute to your charges.

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 employer name prior to your visits in order to bill the worker's compensation insurance company.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least a 24 hour notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice. After three missed appointments without proper notification to our practice, you will be dismissed from the practice.

SOCIAL SECURITY NUMBER: We require a valid social security number be provided for the financial responsible party. If you do not wish to provide us with this number, all charges are required to be paid in full before services can be rendered. We will reimburse any funds that insurance pays.

THE UNDERSIGNED CERTIFIES THAT HAVING READ THE FORGOING, RECEIVING A COPY THEREOF IF REQUESTED, AND IS THE PATIENT OR DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Patient/Guarantor Signature_____ Date_____

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