NSC
Newport Surgery Center

PATIENT REGISTRATION FORM

Patient Name:_____ Social Security Number: _____
Last Name First Name Middle Initial

Address:_____
City:_____ State:_____ Zip:_____
Driver's License: _____ State:_____ Other Photo ID Type:_____
ID:_____ Gender: ☐ F ☐ M ☐ _____Date of Birth:_____ Age: _____
Month Day Year
Marital Status:_____ Primary Phone #:_____
Email Address: _____

Allergies / Sensitivities - Drugs, Latex, Food: _____
Emergency Contact: _____ Contact Phone: _____

Employer:_____ Business Phone #:_____
Business Address:_____
City:_____ State:_____ Zip:_____
Name of Spouse/Parent: _____ Social Security Number: _____
Spouse/Parent Address: _____ Primary Phone #:_____
Spouse/Parent Employer:_____ Business Phone #:_____
(Required only if patient is a minor) Parent Driver License #:_____
State:_____ Other Photo ID Type:_____ ID #:_____

CONSENT TO USE & DISCLSURE OF PROTECTED HEALTH INFORMATION
AUTHORIZATION TO APPEAL, DISPUTE AND ARBIRTRATE CLAIMS
ASSIGNMENT OF RIGHTS

I, the undersigned, hereafter referred to as 'the patient/' do hereby authorize Newport Surgery Center, hereafter referred to as "provider of service" to obtain, disclose and/or release my protected health information to others for the purposes of treatment, obtaining payment, or reporting the day-to-day health care operations of the practice. This assignment shall Include but is not limited to, all rights available to me pursuant to the State of California.

I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the Insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

I, the patient, do hereby authorize my health insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. further, In the event that the health carrier falls to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

To prevent the insurance carrier and/or the vendor designated by the Insurance carrier from refusing to accept my Assignment or submitting a challenge to my Assignment as being Invalid, I appoint and authorize Newport Surgery Center or any authorized representative on behalf of NSC to file an Appeal, Dispute, Contest and/or Arbitrate any unfairly processed claims against the insurance carrier In my name, for the services that were provided to me.

I have been advised and I acknowledge that if an arbitration and/or lawsuit is filed against my insurance company for unfairly processed claims for services provided to me, the attorney will be appointed and chosen by the "provider of the service" In order to collect on all outstanding billed charges wrongfully denied claims. In consideration, this medical provider does not participate or contracts with any health Insurers, therefore will not accept reduced or unreasonable benefits warranted by the Insurer and will pursue legal actions If necessary to recover outstanding charges.

Patient's Signature: _____ **Today's Date:** _____

LABEL