ROXBURY
SURGERY CENTER

SUBMIT FORM

Patient's Name: Last, First, Middle Initial		S.S. #	Marital Status M I S I D I W I Sep ❑ ❑ ❑ ❑ ❑	Birth Date
Street Address		City, State. Zip	Preferred Phone	
Patient's Employer		Occupation	Alternate Phone	
Employer's Address		City, State. Zip	OK Leave Message ❑ YES ❑ NO	
Drug Allergies, If Any	Are you Diabetic?	Driver's License#	Email Address	

Spouse/Partner's Name: Last, First, Middle Initial	S.S. #	Birth Date
Address if Different from Patient	City, State. Zip	Preferred Phone
Spouse/Partner's Employer	Occupation	Alternate Phone
Employer's Address	City, State. Zip	OK Leave Message ❑ YES ❑ NO

In Case of Emergency, Notify	Relationship	Home Phone
Referred By	Relationship	Home Phone
Insured Name	Effective Date	Certificate/ Policy# Group#
Name of Insurance Company	HMO ❑ YES ❑ NO	Subscriber #
Insurance Address		City, State, Zip
Referring Physician		Business Phone

AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS RELEASE OF MEDICAL INFORMATION FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges incurred at the time of service or for any charges not covered by an approved contractual-provider insurance or insurance benefits. I am also responsible for any collection fees or legal costs incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered. I hereby authorize payment of benefits directly to Roxbury Surgery Center for the procedural, surgical and/or medical benefits if any, otherwise payable to me for their service.

HMO patients please be aware you are financially responsible for all unauthorized services.

Roxbury Surgery Center is a physician owned facility. I understand that my physician may have financial interest or ownership in Roxbury Surgery Center. A full list of physician owners will be provided at my request in writing.

I hereby authorize treatment by Roxbury Surgery Center.

Signature of Patient, Guarantor or Guardian	Date