SURGICAL SPECIALISTS Hilton General & Laparoscopic Surgery, PA (HHGLS)
Thomas P. Rzeczycki, MD, FACS Robert L. Soares, Jr., MD, FACS Richard L. Hussong, Jr., MD, FACS
25 Hospital Center Commons, Suite 100 Hilton Head Island, SC 29926 (843) 681-9489

PATIENT ENROLLMENT

Last Name ___________________________________ First Name ___________________________ MI _____________

Mailing Address ____

City ____ State ___________________ Zip Code __________________

Home Phone _______________________________ Work Phone ____________________________ Ext ______________

Date of Birth _______________________________ Age ____________ SSN ___________________________________

Sex (circle one) M F Marital Status (circle one) Single Married Divorced Separated Other

Employer ____

Insurance Policy Holder Social Security # (necessary to file with your insurance) _________________________________

Our office appointment schedule is subject to change at a moment's notice due to emergencies, so please list a phone number where we may reach you in case your appointment needs to be changed:

_______________________________________ (circle one) Home Work Cell

I give permission to HHGLS to leave messages regarding my appointments and/or test results:

On my answering machine: Yes No with my spouse: Yes No

Your designated family member/friend who may access your medical records and discuss your medical conditions:

Name _______________________________ relationship ____________________ phone ___________________

**************PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE STAFF FOR COPYING**************

FINANCIAL AGREEMENT

Payment is expected at the time of service. Cash, check or major credit card is accepted in the form of payment. Third party payments of assignment are generally accepted for services. All deductibles, co-pays, and co-insurances are due at the time of service. I hereby authorize the payment of any insurance or other medical benefits to Hilton Head General & Laparoscopic Surgery, PA (HHGLS).
I understand that my insurance, if any, is a contract between myself and my insurance company, except in certain cases where Drs. Soares, Rzeczycki, and Hussong have signed a contract with my PPO or other third party**. I understand that any balance due after my insurance has processed will be my responsibility,** and shall be paid within 30 days of the first billing, unless other arrangements are made.
I hereby authorize the payment of any insurance or other medical benefits to HHGLS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the HHGLS NOTICE OF PRIVACY POLICIES, detailing how my information maybe used and disclosed as permitted under federal and state law. I understand the content of the Notice and I request the following restriction concerning the use of my medical records: ____
____
____
Further, I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to the medical assignment of benefits applies.
Signed ____ Date ____
If not signed by the patient, please indicate relationship to patient.
Relationship _______________________________________ Witnessed ____

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OFFICE USE ONLY

If the patient or patient representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented and sign below:
Presented on (date & time) ____________________ By (name of staff member) __________________________________