ISLAND SURGICAL CENTER
171 Farenholt Avenue
Tamuning, GU 96913
Telephone: 671-646-0443/4

FOR OFFICE USE ONLY

Dialysis @: US Renal: TAM____ SIN_____ HAR____
Tumon Kidney Center _____
Days: M ____ T ____ W ____ Th ____ F ____ S ____
Time: _____

REGISTRATION

Sex: ☐ Male ☐ Female Age: _____
☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date _____

Patient name _____ _____
Last Name, First Name, Initial Patient Social Security #

Birthdate _____ Telephone: (H)_____ (W) _____ (C) _____

Responsible Party (If a minor) _____ Relationship: _____

Mailing Address _____
Post Office Box or Street Address City, State, Zip Code

Patient Employed By _____ Occupation _____

Business Address _____ Phone _____

Emergency Contact: _____ Relationship: _____ Phone _____

Who is your Primary Care Physician? _____ Who is your Referring Physician? _____

DO YOU HAVE MEDICAL INSURANCE? YES ☐ NO ☐ IF YES,

Primary Insurance Name _____ Subscriber # _____

Subscriber's Name _____ Subscriber's SSN # _____

Relationship to Patient _____ Subscriber's Birthdate _____

Secondary Insurance Name _____ Subscriber # _____

Subscriber's Name _____ Subscriber's SS # _____

Relationship to Patient _____ Subscriber's Birthdate _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X_____ _____
Signature of Insured / Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

X_____ _____
Signature of Insured / Guardian **Date**

Island Surgical Center

171 Farenholt Avenue
Tamuning, Guam 96913
Tel: 646.0443 646.0444
Fax: 646.0440

PATIENT NO CALL, NO SHOW AGREEMENT

To our Valued Patients:

We have been experiencing a significant amount of broken appointments or short notice of cancellations. **A fee of $50.00 will be imposed for appointments missed or cancelled without 24-hour notice. A fee of $100.00 will be imposed for procedures missed or cancelled without 24-hour notice** and must be paid in order to make another appointment.

Please help Island Surgical Center Staff plan your care by notifying the office at least one day in advance if you need to reschedule your appointment.

Please note that this policy was designed as a courtesy for other patients awaiting an appointment or procedure date and time.

Thank you for your understanding.

Acknowledged by: _____
Print Name & Date

_____
Patient Signature

_____ _____
Island Surgical Center Staff Date

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OUTPATIENT TERMS AND CONDITIONS

1. AUTHORIZATION FOR TREATMENT: I hereby consent to and authorize any procedures or treatments necessary to my healthcare as advisable in the judgement of the physician in charge. I understand that these procedures or treatments will be fully discussed with and explained to me.

2. RELEASE OF INFORMATION: I hereby authorize Island Surgical center to disclose all or any part of my medical record to any person or corporation which is or may be liable under a contract to Island Surgical Center or to myself or to my family members or employer for all or part of the doctor's charge, including, but not limited to hospital of medical service companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer. Island Surgical Center will honor any specific authorization of any part of my medical records. I understand that I will have to submit this request in writing and it shall be effective until such time that I revoke request in writing.

3. ASSIGNMENT OF INSURANCE BENEFITS: Should the undersigned be entitled to medical benefits of any type whatsoever arising out of any policy of insuring patient or any other party liable to patient, these benefits are hereby assigned to Island Surgical Center for application on the patient's bill.

4. FINANCIAL AGREEMENT: The undersigned agrees whether he signs as agent of patient that in consideration of the services rendered to the patient, he hereby individually obligates himself to pay to Island Surgical Center, within thirty (30) days of the bill date any portion not covered by his or her insurance (s).

THE UNDERSIGNED agrees that any amount not paid in accordance with the above financial agreement shall be considered past due.

THE UNDERSIGNED certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

ISC Chart Number:_____ **Insurance:**_____

_____ _____

Signature of Patient **Signature of Patient's Guarantor**

_____ _____

Print Patient Name **Print Guarantor Name**

_____ _____

Date **Date**

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only.

☐ Written Communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number _____

☐ Work Telephone _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only.

☐ Other _____

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

----------TO BE COMPLETED BY OFFICE ----------

Record of Disclosures of Protected Health Information

Date	Disclosed to whom address or fax number	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)
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(1) Check this box if the disclosure is authorized
(2) Type key T = Treatment Records ; P = Payment Information ; O = Healthcare Options
(3) Enter how disclosure was made: F = Fax ; P = Phone ; E = Email ; M = Mail ; O = Other