

**SANDY CREST MEDICAL CENTRE**

LAST NAME OF PATIENT: \_\_\_\_\_

NAME OF PATIENT AT BIRTH: \_\_\_\_\_

PATIENT'S FIRST NAME & INITIAL: \_\_\_\_\_

BIRTH DATE OF PATIENT: \_\_\_\_\_

NAME OF GUARDIAN OR INSURED: \_\_\_\_\_ SEX: \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER: ( ) \_\_\_\_\_

TEMPORARY ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER: ( ) \_\_\_\_\_

EMPLOYER (NAME, ADDRESS, TEL): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( ) \_\_\_\_\_

DRIVER'S LICENSE NUMBER: \_\_\_\_\_

SS # OR EQUIVALENT: \_\_\_\_\_

DATE OF DEPARTURE FROM COUNTRY

OF ORIGIN: MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_ YEAR: \_\_\_\_\_

DATE OF DEPARTURE TO COUNTRY

OF ORIGIN: MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_ YEAR: \_\_\_\_\_

NAME & ADDRESS OF RELATIVE OR

FRIEND: \_\_\_\_\_

\_\_\_\_\_

NAME & ADDRESS OF TRAVEL &/OR \_\_\_\_\_

\_\_\_\_\_

PRIVATE INSURANCE: \_\_\_\_\_

\_\_\_\_\_

INSURANCE POLICY NUMBER: \_\_\_\_\_

INSURANCE GROUP NUMBER: \_\_\_\_\_

**RECOGNITION OF DEBT**

I PLEDGE TO FORWARD TO \_\_\_\_\_ ANY AND ALL PAYMENTS I SHALL RECEIVE FROM THE PROVINCIAL HEALTH INSURANCE AND FROM MY PRIVATE OR TRAVEL INSURANCE FOR SERVICES RENDERED TO ME. I RECOGNIZE THAT I AM RESPONSIBLE FOR THE FEES CHARGED EVEN IF MY INSURANCE(S) REFUSES TO PAY. I KNOW THAT I MIGHT BE SUBJECT TO LEGAL PROCEEDINGS IN THE COUNTRY OF ORIGIN AND/OR THE RESPECTIVE STATE IN THE U.S.A.

SIGNED ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_.

SIGNATURE: \_\_\_\_\_

**SANDY CREST MEDICAL CENTRE**

**CERTIFICATE OF AUTHORIZATION**

NAME OF INSURANCE: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

TELEPHONE #: (        ) \_\_\_\_\_

AUTHORIZATION #: \_\_\_\_\_

I CONFIRM TO HAVE OBTAINED AUTHORIZATION FROM MY INSURANCE COMPANY FOR MY VISIT TO THE DOCTOR.

SIGNATURE OF PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

NOTE: THE TELEPHONE NUMBER TO CALL FOR THE AUTHORIZATION SHOULD BE ON THE PATIENT'S INSURANCE CARD.

**SANDY CREST MEDICAL CENTRE**

**PERMANENT LIFETIME SIGNATURE**

PATIENT'S NAME: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
ASSIGNMENT OF INSURANCE BENEFITS**

I authorize any holder of medical or other information about me to release to the insurance carriers any information needed for this insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the hospital and/or clinic/physician furnishing the services. I understand that I am responsible for any amounts applied to the deductible, as well as any **non-covered services for charges not paid by my insurance**. Permission to render medical services is hereby given.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## **SANDY CREST MEDICAL CENTRE**

DEAR PATIENT:

WE ARE MAILING THE CLAIM FOR OUR SERVICES TO YOUR HEALTH INSURANCE TODAY. PLEASE PROMPTLY COMPLY WITH ANY REQUESTS FOR INFORMATION FROM YOUR INSURANCE CARRIER. PAYMENT MAY BE LESS THAN YOUR CHARGES. PLEASE CAREFULLY **PRESERVE** THE EXPLANATION OF BENEFITS AND FORWARD IT TO US ALONG WITH THE PAYMENT SHOULD YOU RECEIVE THE PAYMENT.

IF YOU PROVIDED PROVINCIAL OR MEDICARE INFORMATION FROM YOUR COUNTRY OF ORIGIN, WE WILL REQUIRE THE EXPLANATION OF BENEFITS IN ORDER TO FILE WITH YOUR TRAVEL INSURANCE. PLEASE SEND US ALL PAYMENTS YOU MAY RECEIVE FROM YOUR INSURANCE CARRIER. ALL CHEQUES MUST BE ENDORSED. YOU WILL BE BILLED FOR ANY DIFFERENCES DUE TO FOREIGN EXCHANGE ADJUSTMENTS.

THANK YOU.