

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.