

Mountain West Surgical
Kevin Rayls, M.D., FACS
Stephen Horsley MD
8530 W. Sunset Rd Suite 240
Las Vegas, NV 89113
(702) 796-0022 Fax (702) 796-0038

PATIENT INFORMATION

Patient Name _____
Last Name First Name Initial
Sex M F Marital Status M S D W Age _____ Birthdate _____ SS No. _____
Spouse/Parent (if minor) Name: _____ Birthdate: _____
Home Address _____ Apt.# _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Employer _____ Address _____
Person Financially Responsible _____
Emergency Contact(not living with you) _____ Phone# _____

INSURANCE COVERAGE

PRIMARY INSURANCE

Subscriber's Name _____
Ins. Co. _____
Ins. Phone _____
Employer _____
SS No. _____ Birthdate _____
ID# _____ Group# _____
Co-Pay _____ Deductible _____

SECONDARY INSURANCE

Subscriber's Name _____
Ins. Co. _____
Ins. Phone _____
Employer _____
SS No. _____ Birthdate _____
ID# _____ Group# _____
Co-Pay _____ Deductible _____

CONSENT TO TREAT

I consent to any medical or surgical treatment rendered the patient under the general or special instruction of the Physician .

Patient Signature or If Minor, Parent/Guardian

Date

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Mountain West Surgical all medical benefits, if any, including those otherwise payable to me for services rendered. I understand that I am financially 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.

Signature of Insured/Guardian

Date

PATIENT BALANCE POLICY

I understand that any balance on my account which is determined to be my responsibility must be paid in full within 30 days from the date the balance became my responsibility. If the balance is not paid in full within 30 days, I understand I will be charged interest in the amount of 3% per month as long as the balance remains unpaid. I further understand that should I be allowed to make monthly payments on my unpaid balance, there is no grace period on the monthly due date and I will be charged a \$15.00 late fee if my monthly payment is not received by the close of business on the agreed upon due date. I further understand that should I fail to make payment on my account as agreed upon, my account will be sent to an outside collection agency and may affect my credit rating. I understand that there is a \$20.00 charge on all returned checks.

Signature of Patient/Responsible Party

Date