Aurora Health Care
Patient Demographic Facesheet, Authorization and Assignment

PATIENT DEMOGRAPHICS

Name:		MRN:	
Address:		Legal Sex:	
City:		DOB:	
		Marital Status:	
Primary Care:			
Language:		*Primary Phone:*	
Ethnicity:		Home Phone:	
Race:		Work Phone:	
EMPLOYER		Mobile Phone:	
Employer Name:			
Address:			

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Mobile Phone	Work Phone
1.					
			1st Contact Primary Phone:		
2.					
			2nd Contact Primary Phone:		

GUARANTOR INFORMATION

Guarantor:		DOB:	
Address:		Sex:	
		Home Phone:	
		Account Type:	
Relation to Patient:		Guarantor ID:	
GUARANTOR EMPLOYER		Status:	
Employer:		Employer Phone:	

Notice of Privacy Practices - I acknowledge that Aurora Health Care has provided me a copy of its Notice of Privacy Practices, Payment Policy, and Payment Rights.

Assignment of Insurance Benefits/Charges/Refunds

I hereby assign all insurance benefits, to include major medical benefits to which I am entitled, to Aurora Health Care. I hereby authorize and direct my Insurance carrier(s), including Medicare, Medicaid, private insurance and other health/medical plan, to issue payment directly to Aurora Health Care. I understand that I am financially responsible for the services rendered. I agree to pay all charges that are not covered by my insurance, subject to Medicare and Medicaid advance notice requirements, if applicable. To the fullest extent of the law, I authorize Aurora Health Care to transfer payments made by, or on my behalf, and otherwise refundable to me to other Aurora Health Care accounts for which I am responsible. This assignment is valid until my accounts are paid in full. I understand that I will be given a copy of the fee schedule. I agree to pay for the services provided including co-payments and deductibles that I may owe as well as missed appointment fees, if applicable, that are not covered by my insurance. If the laws of the State of Wisconsin allow it, I give permission to transfer overpayments from one Aurora account to another Aurora account that I am responsible for until all Aurora accounts that I am responsible for are paid in full.

Authorization for Disclosure of Information for Payment and Care Evaluation

I authorize Aurora Health Care to provide information from my medical records relating to my substance use disorder diagnosis and treatment for payment purposes to my health plan and other identified payers:

Insurance Company(s)
who is/are responsible for payment for the services provided to me by Aurora Health Care and to utilization and quality review agencies under contract with such third party payer(s) to provide concurrent and retrospective review of treatment appropriateness. It is understood that the specific type of information to be disclosed includes my substance use disorder information which may be included within the psychiatric/psychological evaluation, discharge summary, history and physical, progress notes, physician orders and other related diagnostic and treatment material. I understand that I have the right to inspect and receive a copy of the information to be disclosed. This consent to the release of information shall remain effective until Aurora Health Care has been reimbursed for all services provided. I understand that I may revoke my authorization in writing at any time except to the extent that Aurora Health Care has already acted in reliance upon the authorization.