HEART AND VASCULAR CARE

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Last Name:_____ **First Name:**_____ **MI:**_____ **Preferred Language:**_____

Date of Birth:_____ **Social Security #:**_____ **Sex:** Male Female **Marital Status:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Phone#:_____ Cell, Home Or Work? **Secondary Phone#:**_____ Cell, Home or Work **Email:**_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasion ☐ Native Hawaiin or other Pacific Islander ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Occupation:_____ **Employer:**_____ **Address:**_____

Spouse Name:_____ **Guardian Name If other than Patient:**_____

Referring or Primary Care Physician:_____ **Phone#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Emergency Contact Name:_____ **Relationship:**_____ **Phone#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name:_____ **Phone#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Policy#:_____ **Group#:**_____

Policy Holder's Name:_____ **Relationship:**_____

Policy Holder's Date of Birth:_____ **Policy Holder's Social Security#:**_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name:_____ **Phone#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Policy#:_____ **Group#:**_____

Policy Holder's Name:_____ **Relationship:**_____

Policy Holder's Date of Birth:_____ **Policy Holder's Social Security#:**_____

ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT
(This is necessary to facilitate the processing of insurance claims and assure payment)

1. I hereby authorize and give permission for Heart and Vascular Care to disclose my personal health information *(PHI) for insurance and treatment purposes only. I am allowing Heart and Vascular Care to release all PHI necessary for payment and treatment of my specific health problem.

2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan.

3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that payments are due at the time services are rendered.

4. I understand and agree that in the event that I fail to make payment for services rendered to me, my name a account may be turned over to an attorney or collection agency and agree to pay the collection agency's fee for collection, court costs and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

Signature:_____ Date:_____

*Please refer to Heart and Vascular Care posted "Notice of Privacy Practices" for specific information regarding this practice's use of personal health information (PHI).

ESTABLISHED PATIENTS ONLY:

Your insurance company requires that we have an updated signature on file annually.

By signing, I am certifying that my information is correct and up to date.

Updated: _____ _____
Signature Date

Updated: _____ _____
Signature Date

Updated: _____ _____
Signature Date

Updated: _____ _____
Signature Date