Huntsville Cardiovascular Clinic, P.C.

To be filled out as a new patient and once a year

4601 Whitesburg Dr. • Suite 201 • Huntsville, AL 35802 • Phone (256) 880-1050 • Fax (256) 880-7477

Patient Information (Please Print)

Today's Date ______________________

Patient Name ____ Date of Birth ______________ Age ________

Maiden or Previous Name ____

Street ____

City ___________________________ State ______ Zip __________ Social Security # ____________________

Home Phone _____________________ Cell Phone _____________________ Cell Phone Carrier _______________

E-Mail Address ____

*** Appointment reminders will be called, e-mailed & a text message sent. ***

Sex F / M (Circle One) Race/Ethnicity ______________________________ Marital Status ________________

Employer ____ Occupation _______________________________

Work Phone ________________________________ Ext. ___________

Spouse's Name ____ Spouse's Social Security # ___________________

Spouse's Employer _______________________________________ Spouse's Occupation ________________________

Spouse's Phone Number(s) ____

In addition to filling out the following insurance information, please give all insurance cards to receptionist.

Primary Insurance _________________________________ Secondary Insurance ___________________________

Contract/Policy # __________________________________ Contract/Policy # ______________________________

Group # ____ Group # ____________________________________

Cardholder Name _________________________________ **Cardholder Name** ___________________________

Cardholder Date of Birth ____________________________ **Cardholder Date of Birth** _____________________

What hospital does your insurance require you to use? Huntsville Hospital / Crestwood / Any (Please circle one)

Responsible Party (Only complete if responsible party is someone other than the patient)

Name ______________________________________ Relationship _____________ Employer __________________

Home Address ____

Home Phone _________________________ Work Phone __________________ Cell Phone __________________

Emergency Contact

Name ___________________________ Relationship ____________________ Phone Number ________________

PLEASE COMPLETE OTHER SIDE OF THIS FORM

TEST RESULTS, MEDICATION REFILLS, ETC. will not be discussed with anyone other than the patient **UNLESS** you list other family members or friends below. We must have a signed consent from you.

I, the undersigned, authorize the following FAMILY MEMBER/FRIEND to obtain medical information from my record (such as test results) or to request refills of medications on my behalf.

Name ____ Relationship __________________________

Name ____ Relationship __________________________

____ ________________________________

Patient Signature **Date**

FINANCIAL POLICY

Thank you for allowing us the opportunity to participate in your medical care. We would like to assist you in understanding the financial policies of this office. If you have any questions about the following information or any uncertainty regarding insurance coverage please ask for assistance.

- We will file your primary insurance and secondary insurance for you as a courtesy.
- The patient/responsible party is ultimately responsible for payment of all services.
- Copayments, deductibles, and non-covered services are due at the time of service. We accept cash, checks, VISA, and Mastercard as payment.
- There is a $30 fee for returned checks.
- Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event your insurance does not pay within 60 days of the date of service, the account will be forwarded to you for payment.
- Changes in insurance information should be communicated with our office as soon as possible.
- If the service provided is or may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other insurance we will notify you in advance and ask you to sign an "Advance Beneficiary Notice".
- Accounts over 60 days past due will be turned over to a third party collection agency. Your future status with the office will be considered at such time.

FINANCIAL RESPONSIBILITY: I have read, understand and agree to follow the financial policy of Huntsville Cardiovascular Clinic, P.C. I agree to be totally responsible for all charges for services rendered including any non-covered charges.

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Responsible Party Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize Huntsville Cardiovascular Clinic, P.C., to release any medical information which may be necessary for treatment, payment, or healthcare operations.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payment of benefits to Huntsville Cardiovascular Clinic, P.C., and agrees to assist, as needed, in processing all claims for benefits.

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Patient Signature **Date**