Advanced Cardiovascular Care Of Yuma

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Board Certified in Cardiovascular Medicine
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Patient Information Sheet

Name: _____ **Date of Birth:** _____
Mother's Maiden Name: _____ **Social Security #:** _____
Home Phone #: _____ **Cell Phone #:** _____ **Sex:** M F **Age:** _____

Local Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____
Months at Local Address (From – To): _____

Out of State/Summer Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____
Months at Out of State Address (From – To): _____

Patient Marital Status: Single _____ Married _____ Widow/er _____ Divorced _____
Patient Employment Status: Employed _____ Not Employed _____ Student _____ Retired _____
Employer: _____
Employer Address: _____ **Employer Phone#:** _____

Preferred Language _____ **Religion:** _____
Ethnicity: _____ **Race:** _____
Referring Physician/Source: _____

SPOUSE INFORMATION: (Include SS# and DOB only if spouse is Insurance Policy Holder)
Spouse Name: _____ **Sex:** M F **Age:** _____
Spouse's Social Security #: _____ **Date of Birth:** _____

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS UNDER 18):
Responsible Party Name: _____
Relationship to patient: _____
Address: _____ **City:** _____ **State:** _____

INSURANCE:
Primary Insurance: _____
ID#: _____ Employer Name: _____ Group #: _____
Insured/Policy Holder: _____ Relationship to Patient: _____

Secondary Insurance: _____
ID#: _____ Employer Name: _____ Group #: _____
Insured/Policy Holder: _____ Relationship to Patient: _____

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Patient Information Sheet - Continued

Please list the family members or other persons, if any, whom we may contact concerning your general medical condition, diagnosis, treatment, and billing questions:

Name: _____ Relationship:_____ Phone #: _____
Name: _____ Relationship:_____ Phone #: _____
Name: _____ Relationship:_____ Phone #: _____

Please list the family members or significant others, if any, whom we may contact about your medical condition only in an emergency:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Please list a preferred telephone number, <u>if other than your telephone number listed</u>, where you want to receive calls about your appointments, lab, x-ray results, or other health care information
Phone#: _____

Can confidential messages be left on your home answering machine or phone voicemail?
YES:_____ NO:_____

If you do not have voicemail, can a confidential message be left at your place of employment?
YES:_____ NO:_____

I Request that payment under my insurance program be made to either me or on my behalf to Advanced Cardiovascular Care Of Yuma, for any services furnished to me by Advanced Cardiovascular Care Of Yuma. I authorize the release of any medical information necessary for the purpose of evaluating benefits or processing of a claim. I also understand that payment for services are due within 30 days of billing. I also understand that I am financially responsible for all charges whether or not covered by my insurance. If I do not pay the balance owed and a collection agency and or attorney is used I am responsible for any additional charges.

_____

Signature **Date**

Please Read and Initial The Following Statements

Initial	**Consent for Medical Release** The Above information is true to the best of my knowledge. I hereby authorize Advanced Cardiovascular Care of Yuma, to release information required in the course of my examination or treatment. (including insurance companies, durable equipment providers, physician's office, etc)
Initial	**Consent For Financial Release** Authorization to pay: I hereby authorize payment directly to Advanced Cardiovascular Care Of Yuma, for medical benefits, if any, and otherwise payable to me for services. I understand I am financially responsible for the charges not covered by my insurance. I authorize the use of this signature on all my insurance claims.
Initial	**Consent For Medical Treatment** Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital.

Acknowledgment Of Receipt Of Privacy Practice Notice

By signing this acknowledgment you are not agreeing or disagreeing, only stating that it was given to you for review and record purposes for further references.

I

(**Patient Name**)

Have received and / or been given a copy of the Privacy Practices of Advanced Cardiovascular Care Of Yuma, on

(**Date**)

_____.

(**Patient / Guardian Signature**)

Financial Policy

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF OUR FINANCIAL POLICY.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office. If failure to timely provide this information or assistance results in a denial of coverage, you may become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, **or** if the services provided are not covered under your health insurance plan, then you are responsible for paying for all services and fees at the times services are rendered. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.
Please Note: In certain circumstances we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, co-insurance, deductibles and fees deemed non-covered by your insurance company), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts Visa®, Mastercard®, Discover® and Personal Checks. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of $35.00, which shall be due immediately.

_____ _____

Signature of Patient or Responsible Party ***Date***

_____

Print Name of Patient or Responsible Party