Premier Cardiovascular Institute

Last Name: _____ **First Name**: _____ MI____ Date of birth:_____

Address:_____ City:_____ State:____ Zip code:_____

Phone number (Cell): _____ E-Mail address:_____

Gender: M , F || SSN: _____ || Driver's license: _____

Primary care provider: _____

Referring provider: _____

How were you referred to us (Google, newspaper, other doctor): _____

Reason for visit:_____

Medications:_____

Allergies:_____

Tobacco and alcohol use:_____

Preferred pharmacy: _____

Emergency Contact Information:

Name : _____ Phone number: _____Relation: _____

Employment Information:

Occupation: _____ Employer: _____

Work address: _____

Work phone: _____

Insurance (Circle): BC/BS, Medicare, Medicaid/Public Aid Other: _____

Policy number::_____Group # (BC/BS only) : _____

Policy holder's name:_____Date of birth _____ SS#:: _____

Secondary insurance:_____

Authorization for Claims Payment and Reviews:

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to **Premier Cardiovascular Institute Inc** (or its affiliate) and each of theindependent contractor physicians and/or professional corporations for services rendered to me. The direct payment herebyassigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical Fbenefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the **Premier Cardiovascular Institute Inc**. (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to **Premier Cardiovascular Institute Inc**. for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

Patient signature: _____ Date: _____

- **No show fees $50 (must cancel 24 hrs in advance)**
- **Procedure cancellations(Echo, Stress Test): $75(must cancel 72 hrs in advance)**