Advanced Cardiovascular Clinic

6122 West Pierson Rd
Unit 1
Flushing MI. 48433
(810) 600-3399
(810) 600-3398 Fax

PATIENT REGISTRATION FORM

Today's Date _____/_____/_____

Last_____ First_____ Middle_____

Address _____ City_____ State _____ Zip _____

Gender: M or F DOB _____/_____/_____ Social Security _____/____/_____

Phone Number _____-_____-_____ Cell Phone _____-_____-_____

Email Address or None (for patient portal):

_____

Pharmacy:

Name_____

Address_____

Phone (_____) _____

Hospital: Please circle one: McLaren Hurley Genesys

Employer Information:

Company Name/Retired/Disabled_____ Phone _____-_____-_____

Address _____ Full Time or Part Time

In Case of Emergency:

Name _____ Phone _____-_____-_____

Relationship to You _____Initial if they can have access to your chart HIPPA:

Name _____ Phone _____-_____-_____

Relationship to You _____ Initial if they can have access to your chart HIPPA:

Primary Care Doctor:

Physicians Name _____ Phone _____-_____-____

Address _____

_____

Please see back of page

YOUR INSURANCE CANNOT BE BILLED WITHOUT FOLLOWING INFORMATION BEING COMPLETED

AUTHORIZATION AND RELEASE OF INFORMATION:

I hereby authorize Advance Cardiovascular Clinic to furnish and/or obtain information to my insurance carriers, hospital, and physicians concerning my illness, surgery, and/or accident. I assign to the physician all payments for medical services rendered. I understand that I will be financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature **X**_____ Date _____

FINANCIAL POLICY FORM

1. Each Patient is responsible for his/her own bill.
2. As a courtesy, this office will submit claims to your insurance carrier. It is the responsibility of the patient to provide all insurance policy information or changes to this office upon every visit.
3. It is the patient's responsibility to pursue slow payment or non-payment on the part of his/her insurance company by contacting the insurance company directly regarding the claim.
4. The patient agrees to monthly payments on all accounts that are not covered by your insurance, per the insurance contract. An account becomes delinquent after 30 days of no activity.
5. Patient is responsible for all services not authorized by their primary care physician (referrals\authorizations).
6. I have read, understand, and accept the office procedures sheet.

Authorization and Assignment

I, _____, authorize my insurance carrier or the Health Care Financing Administration to make payments on my behalf directly to Advanced Cardiovascular Clinic. I understand that charges may exceed the payment paid by my insurance carrier and I will be responsible for the same. I understand I am fully responsible for all services including co-pay, deductibles, and rejected or unpaid fees. I hereby, authorize examination and any other medical services deemed necessary by my physician. I have been fully informed as to the nature of the treatment to be performed or administered by Advanced Cardiovascular Clinic. I also authorize the release of any medical information necessary for my insurance company or the Health Care Financing Administration to process claims for services furnished by Advanced Cardiovascular Clinic.

X_____

Patient's Signature (or parent or legal guardian) Date

Office Polices and HIPAA

I have received information on Office Polices and HIPAA Laws.

X_____ _____

Signature Date

Medicare Authorization/Assignment Of Benefits:

I request that payment of authorized Medicare benefits be made to or on my behalf to **Advanced Cardiovascular Clinic,** for any services furnished to me by one of the providers. I authorize any holder of information about me to the Centers for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and on-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

X_____ _____

Patient's name printed SSN or Medicare number

X_____ _____

Patients or Representatives Signature Date

Medi-Gap/Medicare Supplemental Insurance Lifetime Assignment Of Benefits:

I , the undersigned, have Medi-Gap Insurance coverage and assign directly to **Advanced Cardiovascular Clinic**, all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until evoked by me in writing.

X_____ _____

Signature of Beneficiary Date