Advanced Cardiovascular Clinic

5084 Villa Linde Pkwy, Suite 6
Flint MI 48532
(810) 600-3399
(810) 600-3398 Fax

PATIENT REGISTRATION FORM

Today's Date _____/_____/_____

Last_____ First_____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

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

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

Pharmacy:

Name_____

Address_____

Phone (_____) _____

Hospital: Please circle one: McLaren Hurley Genesys

Employer Information:

Company Name _____ Phone _____-_____-_____

Address _____

In Case of Emergency:

Name _____ Phone _____-_____-_____

Relationship to You _____

Name _____ Phone _____-_____-_____

Relationship to You _____

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. 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

Authorization for Medicare Payments

I understand and request that payment of authorized benefits be made on my behalf for services provided by Advanced Cardiovascular Clinic.
I authorize the provider to release to the Social Security Administration, Health Care Financial Administration (HFCA) and agents or carriers, any information needed to determine benefits for services provided.
I permit a copy of this authorization to be used in place of the original. This request is effective until revoked in writing.

X_____ _____

Signature Date