

## Patient Information

Full Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Maiden Name	
Social Security Number	Date of Birth	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Name of Spouse
Physical Address: Street	City	State	Zip
Mailing Address:	City	State	Zip
E-mail address	Home Telephone #	Secondary Phone #	Cellular Phone #
Employer	Occupation	Work Phone #	

### Secondary or Emergency Contacts:

Name	Phone Number	Relationship to Patient
Name (NOT living with patient)	Phone Number	Relationship to Patient

Did a physician refer you to our clinic?  Yes  No

Name and address of referring physician

Please indicate how you heard about us. (please check one)  Hospital Follow-up  Health Fair/Screening  Newspaper  
 Other Patient  Physician  Radio  
 Television  Yellow Pages

Name of your family physician: \_\_\_\_\_

### Guarantor Information (If Person is a Minor):

Name and address of guarantor: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
Relationship of guarantor to patient: \_\_\_\_\_  
Guarantor's Date of Birth \_\_\_\_\_ SS#: \_\_\_\_\_  Male  Female  
 Single  Married  Divorced Phone (Home): \_\_\_\_\_ (Secondary or Cell #): \_\_\_\_\_  
**Guarantor's Employer:** \_\_\_\_\_ Phone: \_\_\_\_\_

## Insurance Information

Medicare: (Medicare #) \_\_\_\_\_  Medicaid: (Medicaid #) \_\_\_\_\_  
 Workers' Compensation - For verification, call: \_\_\_\_\_  
 Private Insurance: (Name of Company) \_\_\_\_\_ Policy #: \_\_\_\_\_  
Secondary: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Name of Insured)  
 Private Insurance: (Name of Company) \_\_\_\_\_ Policy #: \_\_\_\_\_  
Secondary: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Name of Insured)

## Patient Information

I understand that I am responsible for the payment of this account, subject to the terms noted below. I also agree to present my insurance card at each visit to Cardiovascular Institute of the South (CIS) in order to allow for verification of insurance carrier information on file.

**PRIVATE INSURANCE** - As a courtesy to me, CIS will file my claims based on the information provided. Should this information prove incorrect, I am responsible to pay the balance in full. I agree that my insurance benefits may be paid directly to CIS and payment of all deductibles and co-payments are required at the time of service. Any allowable amount not paid by my insurance carrier must be paid within 30 days of receipt of a statement.

**MEDICARE** - CIS accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s) or co-payment(s). If there is a Medicare supplement insurance policy, CIS will file my claims as a courtesy to me, and the benefits may be sent directly to CIS.

**MEDICAID** - I understand that CIS accepts Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or denies these benefits, I agree to be responsible for payment of the account.

**WORKER'S COMPENSATION** - I agree to allow CIS to verify my Worker's Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any requested information sent to my employer or the insurance carrier will also be provided to me. I agree to be responsible for payment of all charges which are not paid by my employer or its Worker's Compensation insurance carrier.

**NO INSURANCE** - If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges at the time of service.

**RELEASE OF INFORMATION** - Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), CIS has my permission to furnish same.

**If I fail to make any payment due as outlined above or as agreed upon, CIS may turn this account over to a collection agency and/or attorney for handling. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney.**

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Patient/Responsible Party

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Date