

Adult Patient Contact & Insurance Information

Patient's Name		Today's Date	
	Last:	First:	MI:
Age	Date of Birth	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
Mailing Address		Apt. #	
Street Address <i>(if Different)</i>			
City / State		Zip Code	
Telephone Numbers	Home: (___) ___ - _____	Cell: (___) ___ - _____	
	Work: (___) ___ - _____	Other: (___) ___ - _____	
e-mail Address			
Social Security #		Marital Status	
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Employment Status <input type="checkbox"/> Work Full-time <input type="checkbox"/> Work Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <i>(if retired, complete employer information)</i>			
Position Held			
Employer Name			
Employer Address			
City / State		Zip Code	
Employer Phone		# Years Employed	
(___) ___ - _____			
Spouse Name		Date of Birth	
Social Security #		Phone:	
		Home: (___) ___ - _____ Cell: (___) ___ - _____	
		Work: (___) ___ - _____ Other: (___) ___ - _____	
Employer Name			
Employer Address			
City / State		Zip Code	
Employer Phone		# Years Employed	
(___) ___ - _____			
Nearest Relative <i>Not Living with Patient</i>		Relationship	
Address		Apt. #	
City / State		Zip Code	
Telephone Numbers		Home: (___) ___ - _____ Cell: (___) ___ - _____	
		Work: (___) ___ - _____ Other: (___) ___ - _____	
Friend/Neighbor <i>Not Living with Patient</i>		Relationship	
Address		Apt. #	
City / State		Zip Code	
Telephone Numbers		Home: (___) ___ - _____ Cell: (___) ___ - _____	
		Work: (___) ___ - _____ Other: (___) ___ - _____	
Bank Name(s)			
City / State		Zip Code	

Patient's Name		Date of Birth	
Primary Insurance		Policy Holder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Policy Number		Group ID #	
Address			
City / State		Zip Code	
Phone	(___) ___ - _____	Pre-Certification Required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Insurance		Policy Holder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Policy Number		Group ID #	
Address			
City / State		Zip Code	
Phone	(___) ___ - _____	Pre-Certification Required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Insurance		Policy Holder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Policy Number		Group ID #	
Address			
City / State		Zip Code	
Phone	(___) ___ - _____	Pre-Certification Required:	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICARE POLICY

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to Cardiovascular Surgical Clinic of Northwest Arkansas, PA, or to the Center for Chest Care for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

INSURANCE POLICY

We file insurance claims as a courtesy to our patients. We **will not** become involved in disputes between you and your insurance company regarding deductible, covered charges, co-payments, discounts, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

We participate with numerous insurance companies. To "participate" means we accept that particular insurance company's allowables. This does not include your co-insurance, deductible or any service deemed patient responsibility by the rules of your specific insurance company or state assistance program. These are your financial responsibility. Please ask our office personnel if we have a participating contract with your insurance company.

PAYMENT POLICY

After all insurance monies have been received, you are immediately responsible for full payment of any remaining patient balance. If full payment cannot be made, it is your responsibility to contact our office to set up a monthly payment plan.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the answers on the front. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in health status or the personal information on the front.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

The Cardiovascular Surgical Clinic of Northwest Arkansas, PA, or the Center for Chest Care has my permission to request medical records from any and all medical doctors and/or medical facilities as needed relative to treatment. I release you from all legal responsibility that may arise from the act I have authorized above.

In order to protect your privacy, Cardiovascular Surgical Clinic asks you to list the family members, friends or any person(s) who can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

Name of Family Member/Friend	Relationship to You
1.	
2.	
3.	

Signature of Patient (Parent if patient under 18 years of age)

 Date

Submit Form to Clinic

Clear Form

Print Form