

Minor 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: (___) ___ - _____	
e-mail Address	School: (___) ___ - _____	Other: (___) ___ - _____	
Social Security #		Residency Status	<input type="checkbox"/> Lives with both parents <input type="checkbox"/> Lives with Mother <input type="checkbox"/> Lives with Father <input type="checkbox"/> Lives with other relative/guardian
School Status	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/> Not in school <i>(specify)</i>		
School Name			
School Address			
City / State		Zip Code	
School Phone	(___) ___ - _____	Current Grade Level	
Father's Name		Date of Birth	
Social Security #	Phone: Home: (___) ___ - _____	Cell: (___) ___ - _____	
	Work: (___) ___ - _____	Other: (___) ___ - _____	
Employer Name			
Employer Address			
City / State		Zip Code	
Employer Phone	(___) ___ - _____	# Years Employed	
Mother's 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		Relationship	
<i>Not Living with Patient</i>		Apt. #	
Address		Zip Code	
City / State			
Telephone Numbers	Home: (___) ___ - _____	Cell: (___) ___ - _____	
	Work: (___) ___ - _____	Other: (___) ___ - _____	
Bank Name(s)			
City / State		Zip Code	
Name(s) on Accounts			

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

MEDICARE/MEDICAID POLICY

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare/Medicaid 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 the patient's 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 Parent (patient under 18 years of age)

 Date