

**THE CARDIOVASCULAR CARE GROUP**  
**PATIENT INFORMATION SHEET**

**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ APT#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_  
Marital Status: \_\_\_\_\_ Primary Email Address: \_\_\_\_\_

**Employment Information:**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Information:**

**Primary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscribers SS #: \_\_\_\_\_ Relationship to Insured: [ ] Self [ ] Spouse [ ] Other \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscribers SS #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PRIVACY**

**Referring MD:** \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**Primary Care MD.:** \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Please list persons authorized to call on your behalf and with whom we can discuss your medical information. Name , address and phone number

\_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I authorize payment of medical benefits to The Cardiovascular Care Group. **I have read the office financial policy on the reverse side and agree to all terms and conditions.** I authorize The Cardiovascular Care Group to use or disclose any information for treatment, payment, and healthcare operations. I authorize that the physicians and/ or employees of The Cardiovascular Care Group can contact me via all necessary means or leave me a message if they are unable to contact me directly. I acknowledge that I have received a copy of the Notice of Privacy Practices.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**THE CARDIOVASCULAR CARE GROUP**  
**FINANCIAL POLICY**

Because healthcare benefits and coverage have become increasingly complex, we have developed this policy to detail our financial requirements to help you better understand your responsibilities.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from a primary care physician, pre-certification, limits on outpatient charges, specific physicians and/ or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and coinsurance. This applies to all payers regardless of whether or not our physicians participate.

The payment of fees for services is the direct responsibility of the patient. Your health benefit plan involves an arrangement between you, the enrollee, and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what the insurance company determines is medically necessary. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

**Payment Policy Schedule\*:**

Co-payments	Full payment is due at time of service.
Deductible and coinsurance	Full payment is due at time of service.
Non-covered service	Full payment is due at time of service.
Non-participating insurance plan	Full payment is due at time of service.

**Other charges/ fees\*:**

Missed Appointment Fee	The office requires at least 24 hours notice when canceling an appointment. Failure to provide this notice will result in a \$25.00 charge to your account.
Rebillable Fee	\$10.00
Return Check Fee	\$25.00

\* Subject to change at any time

We realize that medical care can become very expensive. If you have concerns about your ability to pay for services, we ask that you contact us for assistance in the management of your account.

Should you have any questions with regard to our financial policies we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you might have.