PATIENT INFORMATION		
Patient #:	**Date of Birth:** **Age:**	**Social Security #:**
Last Name: **First Name:** **Initial:** **Nick Name:**		**Language: English / Spanish / Other**
Marital Status: Married / Single / Divorced/ Widowed / Life Partner / Legally Separated / Other		**Language Assistance Required? Yes / No** **If so; American Sign Language or Interpreter**
Race/Ethnicity: Black-Non Hispanic / American Indian/Alaskan Native / Hispanic / Asian/Pacific Islander / White-Non Hispanic /		**Gender Identity: Male /Female MTF/FTM Gender Neutral / Other / Declined**
Mailing Address:		**City, State, Zip:**
Preferred Phone: **Cell Phone:**		**Home Phone:** **Work Phone:**
Email Address:		**Employment Status: Active Duty Military / Employed / Not Employed / Self Employed / Retired / Student / Homemaker / Other**
Employer:		**Employer Phone:**

PRIMARY CARE – REFERRING PHYSICIAN INFORMATION	
Primary Care Physician:	**Referring Physician:**
How did you hear about us? ‰Billboard ‰Employer ‰Family Member ‰Friend ‰Health Fair Event ‰Insurance ‰Magazine ‰Mail ‰News ‰Physician ‰Radio ‰Television ‰Website ‰Yellow Pages ‰Other	
Preferred Pharmacy:	

RESPONSIBLE PARTY		
Relationship to Patient: ‰Self (If self, skip to Parent/Legal Guardian / Emergency) ‰Spouse ‰Parent ‰Other		
Last Name: **First Name:** **Initial:**	**Date of Birth:**	**Social Security #**
Mailing Address:	**City, State, Zip:**	
Preferred Phone: Cell Phone:	**Home Phone:** **Work Phone:**	
Email Address:		
Employer:	**Employment Status:** Active Duty Military / Employed / Not Employed / Self Employed / Retired / Student / Homemaker / Other	
Employer Address:	City, State Zip:	

INSURANCE INFORMATION		
Primary Insurance		**Policy Subscriber:**
Plan Address:		**Insured Policy ID:**
City, State, Zip:		**Group Number:**
Plan Phone:		**Date of Birth of Subscriber:**
Effective Dates:		**Patient Relationship to Subscriber:**
Second Insurance		**Policy Subscriber:**
Plan Address:		**Insured Policy ID:**
City, State, Zip:		**Group Number:**
Plan Phone:		**Date of Birth of Subscriber:**
Effective Dates:		**Patient Relationship to Subscriber:**

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION	
Parent/Legal Guardian Name:	**Emergency Contact:**
Address (if different than patient):	**Address (if different than patient):** **Relationship to Patient:**
Parent/Legal Guardian Home Phone:	**Emergency Contact Home Phone:**
Parent/Legal Guardian Cell Phone:	**Emergency Contact Cell Phone:**
Parent/Legal Guardian Work Phone:	**Emergency Contact Work Phone:**

Authorization for Treatment/Services and Release of Protected Health Information (PHI) for Payment

I hereby authorize The Cardiac and Vascular Institute (TCAVI) to furnish to my insurance company the requested health information concerning my **cardiovascular condition**. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. I understand that any money received over and above my indebtedness will be available for refund to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize TCAVI to provide such medical services as may be determined to be in my best interest, and (as may be needed in provision of such care) to photograph wounds, incisions, and other pertinent physical findings for inclusion with my PHI. This authorization shall continue and be in full force and effect until revoked in writing by me.

x ____ **Date** _______________________________

Signature

Co-Payments for office visits are to be paid at each visit. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

Medicare and/or Medicare Secondary Insurer Lifetime Signature Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or other carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I request that payment of authorized MEDIGAP benefits be made on my behalf for any services furnished to me by physician/Supplier, I authorize any holder or medical information about me to release to Medicare and/or Medicare secondary insurers any information needed to determine these benefits payable for related services.

x ____ **Date** _______________________________

Signature

Authorization for Release of PHI – Family/Friends/Associates

My signature below serves as authorization for the release of my PHI to and from my family members, friends, and associates listed below. If no one is listed only the PATIENT or LEGAL GUARDIAN can receive PHI. *(Use separate Health Release Form for Providers/Institutions)*

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services.

Name: ____ Relationship: ___________________________

Name: ____ Relationship: ___________________________

Name: ____ Relationship: ___________________________

Patient Name: ____

x ____ **Date** _______________________________

Signature