

Columbia Cardiology Consultants

New _____ Update _____

Chart # _____

Physician Being Seen Today # _____ Referring Physician _____ Date _____

Patient's Name _____
(first) (middle) (last) (Jr., Sr., III, etc)

Patients Address _____
(street) (city) (state) (zip)

Home Phone (____) _____ Marital status _____ Gender _____ Date of Birth _____

Social Security # _____ Race _____ E-mail Address _____

Work Phone (____) _____ Employer _____

Are you retired from the military _____ Do you currently reside in a Skilled Nursing Facility _____

Contact in case of emergency _____ Phone (____) _____

Insurance Information PRIMARY
Company _____

Subscribers Name _____ Soc Security _____ DOB _____

Subscribers Employer _____ Address _____

Policy # _____ Group # _____ Phone # _____

Claims mailing address _____
(street) (city) (state) (zip)

Insurance Information SECONDARY
Company _____

Subscribers Name _____ Soc Security _____ DOB _____

Subscribers Employer _____ Address _____

Policy # _____ Group # _____ Phone _____

Claims mailing address _____

1) It is your responsibility to pay any deductible amount, patient's cost share, or any other unpaid balance not paid for by your insurance, when we file insurance for you. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and the cost of collection:

2) I understand that my eligibility for coverage by _____ cannot be confirmed at this time. I wish to receive medical services from Columbia Cardiology Consultants. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided:

Patient Signature _____ Date _____

3) I hereby assign all medical and/or surgical benefits to which I am entitled to Columbia Cardiology Consultants, to include Medicare, private insurance and other health plans:

Insured's Signature _____ Date _____

4) I hereby authorize Columbia Cardiology Consultants to release all information necessary to secure payment for its services rendered to me and to release information requested by my insurance company, others physicians offices, hospitals or worker's compensation carriers. Further, I authorize Columbia Cardiology Consultantsto secure any of my medical information from other physicians offices and hospitals such as would be necessary in the provision of their care to me:

Patient Signature _____ Date _____