HEART CENTER AT MERCY

PATIENT INFORMATION SHEET

PLEASE PRINT

Social Security # _____ - _____ - _____ Date: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____

State: _____ Zipcode: _____ E-mail address: _____

(Apt. or P.O. Box): _____

Home Phone: (_____)_____ - _____ Work Phone: (_____) _____ - _____ Ext: _____

Cell Phone: (_____) _____ - _____ Birthdate: _____/_____/_____

Marital Status: { }Single { }Married { }Widowed { }Divorced

Employer: _____ { }Full time { }Part time
{ } Retired

Employer Address: _____ City:
_____ State: _____ Zipcode: _____

Employer Phone Number: (_____) _____ - _____

Pharmacy Name: _____

Phone #: (_____) _____ - _____

Referred by: (Circle One and list name): Physician; Patient; Insurance Co.; etc.
_____

In Case of Emergency Contact: _____
Relationship: _____

Phone Number of Emergency Contact: (_____) _____- _____

Nearest Friend of Relative: (Not Living with you):
_____ Phone: (_____) _____- _____

Family Physician: _____Phone: (_____) _____ - _____

Primary Insurance: _____Policy #_____

Secondary Number: _____Policy#_____

(PLEASE BRING A COPY OF YOUR MEDICATIONS WITH YOU)

****IF YOU DO NOT PROVIDE 24 HRS NOTICE TO OUR OFFICE FOR CANCELED APPTS, YOU WILL BE BILLED A FEE OF $20.00**

CONSENT & ASSIGNMENT

(Please read before signing)

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

BLUE CROSS BLUE SHIELD

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and , if greater, I will be Responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

Legal Assignment

The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of fifteen (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

Insurance Assignment

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand that I am financially responsible for charges **not covered** by my insurance.

Managed care

I understand that, without an authorization/referral form from my HMO/PIPA/PPO, I will be financially responsible for charges I incur.

GUARANTEE

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally gurarantees to SPPS and its Successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

Signature: _____ ***Date:*** _____/_____/_____

*****Signature of Patient, Responsible Party, Parent or Legal Guardian*****

Signature: _____ **Date:** _____/_____/_____

(I authorize a copy of this authorization to be used in the place of original)