PATIENT INFORMATION

Patient Information:

DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____

Email: _____ MARITAL STATUS: M S W D

Pharmacy name with address _____

EMERGENCY CONTACT NAME PHONE # _____ RELATIONSHIP _____

May we leave a message on your Answering Machine? Yes No

May we speak to your spouse or your adult child about your condition (or another person)? Yes No

Name

Phone # _____
Phone # _____

_____

WORKMAN'S COMP INFO:

EMPLOYER: _____

CLAIM NUMBER: _____

ADDRESS: _____ PHONE #: _____

OCCUPATION: _____

ADJUSTOR INFORMATION:

NAME: _____ PHONE : _____

INSURANCE INFORMATION: SEE CARDS HANDED IN TO STAFF **PRESCRIPTION PLAN** YES NO

NAME OF **PRIMARY** INSURANCE: _____ COPAY $ _____

ADDRESS: _____ PHONE #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID#: _____ GROUP #: _____

NAME OF **SECONDARY** INSURANCE: _____ COPAY $ _____

ADDRESS: _____ PHONE #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID#: _____ GROUP #: _____

PATIENT FINANCIAL RESPONSIBILITY INFORMATION

RESPONSIBLE PARTY:

NAME: _____ ADDRESS: _____

PHONE #:_____ RELATIONSHIP TO PATIENT: _____

The signature, below, authorized the release of any medical information necessary to process any claims submitted. I, also request payment of benefits be made to ARTERY AND VEIN INSTITUTE,LLC, for any serviced rendered to me by this provider.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. This includes co-payments, non covered services, "less amounts that exceed maximum coverage", co-insurance, deductibles, etc. If my amount is not paid, it could be sent to collections.

Payment of office visit (s) is due at the time of service, except for Medicare patients and for those insurances with which this office has a contractual agreement. CO PAYMENTS ARE DUE AT TIME OF SERVICE.

I authorize any holder of medical information about me to be released to my current medical insurance company, including Centers of Medicare and Medicaid, or my insurance benefits be made/assigned on my behalf to ARTERY AND VEIN INST.

Thank you for choosing Artery and Vein Institute, as your health care provider. Please review our Financial Policy.

PAYMENT IS DUE AT TIME OF CONSULTATION OR OFFICE VISIT

FINANCIAL POLICY OF ARTERY AND VEIN INSTITUTE, LLC

We accept checks, cash and all major credit cards

WE OFFER AN EXTENDED PAYMENT (BUDGET) PLAN. Contact our billing office to make arrangements (484) 370-8140

Insurance Policy:

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your estimated portion be paid at the time of service. To do so, we require your complete insurance information. In the event we do accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

Managed Care Insurance :

Patients enrolled in a managed care health plan are expected to remit appropriate co-payment upon arrival at the office for the appointment. After the practice receives payment from the insurance company and any discount adjustments have been posted, the patient is responsible for any balance due.

Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to Artery and Vein Institute, for any services furnished me. hereby authorize Artery and Vein Institute, LLC to release any medical information necessary to process my claim. I permit a copy of this

authorization to be used in place of the original. The authorization may be revoked either by me or my insurance company at any time in writing.

I have read the Financial Policy. I understand and agree to this Financial Policy.

I have read all of the information and I certify that this information is true and correct to the best of my knowledge. I will notify your office of any changes in the above information.

Patient signature or authorized person:_____

DATE:____/____/____