

# Carolina Vascular Surgery & Diagnostics

Patient information Form

Thank you for choosing Carolina Vascular Surgery & Diagnostics. Please completely fill out this form to ensure quality healthcare service. From time to time we may ask you to review to make sure it stays up to date.

Account:		Social Security #:	
Name	First	MI	Last
Address:			
City:		State:	Zip:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	
Home Phone:		Work Phone:	Ext:
Cellular Phone:		Email Address:	
Occupation:		Driver's License #:	
Employer:			
Employer Address:			
Employer City:		State:	Zip:
Emergency Contact:		Phone Number:	
Referring Physician:		Phone Number:	
Primary Care Physician:		Phone Number:	

## INSURANCE INFORMATION:

We will file your insurance for you. If we do not participate with your insurance you will be responsible for paying at time of service (unless other arrangements have been made) and you will be reimbursed by your insurance company according to the terms of your plan. If we do participate you are responsible for paying your Co-pay, Co-insurance and/ or deductibles for your visit today.

**If you are not able to pay your share today we would be happy to reschedule your appointment.**

	1. Primary Insurance	2. Secondary Insurance
Company Name		
Policy #		
Group #		
Effective Date		
Insured's relationship to patient	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent
<b>Complete section below ONLY if Spouse/Partner or Parent is checked above.</b>		
Name of Insured		
Date of Birth		
SS# Insured		
Insured's Employer		
Insured's Home Phone		
Insured's Work Phone		

Patient Name: \_\_\_\_\_ Chart #: \_\_\_\_\_  
First MI Last

By signing this form, you give consent to **Carolina Vascular Surgery & Diagnostics, PA** (hereinafter "CVSD") to provide medical care reasonable by today's standards, use and disclose your protected health information for the purposes of treatment, payment and health care operations. This also confirms you understand our financial, appointment and insurance policies.

*Please initial each line*

\_\_\_\_\_ I authorize CVSD to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers;

\_\_\_\_\_ I authorize CVSD to release all medical information to my referring physician and my primary (family) physician;

\_\_\_\_\_ I authorize CVSD to release all medical information to any consultants or medical personnel, if referred by CVSD, for the purpose of rendering treatment or to continue my care;

\_\_\_\_\_ I authorize CVSD to contact my insurance company or health plan administrator and obtain all pertinent financial information (including but not limited to deductibles and co-payments) concerning current and prior insurance coverage names and phone numbers of other insurance companies and payments under my policy. I direct the insurance company or health plan administrator to release such information to CVSD;

\_\_\_\_\_ I hereby assign to CVSD any insurance or other third-party benefits available for health care services provided to me. I understand that CVSD has the right to refuse or accept assignment of such benefits.

CVSD's policy is to file your insurance at the time of service as a courtesy to patients; however, if you have commercial insurance, are self-pay, or are out of network, you will be asked to pay at time of service. If your insurance has not paid within 60 days, you will be responsible for all charges incurred. We will accept cash, personal checks, or credit cards (Visa, MasterCard, and Discover). I understand that I am ultimately responsible for charges incurred at CVSD regardless of third party liability. If services are not paid in full at time of service and benefits are not assigned to CVSD, I agree to forward to CVSD all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

You have a legal right to review our **Notice of Privacy Practices** before you sign this consent, and we encourage you to read it in full. Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at 919-235-3400.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I agree that these provisions will remain in effect until I provide written revocation to CVSD.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_