

**GENERAL & VASCULAR SURGEONS, P.C. (Please see other side)**

Patient's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

First Name MI Last Name

Date of Birth: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  Separated

Mailing Address with Apt/Unit/Space #: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_

Street Address with City/State/Zip Code (if different): \_\_\_\_\_

Home Phone w/Area Code: \_\_\_\_\_ email address: \_\_\_\_\_

Cell Phone w/Area Code: \_\_\_\_\_ Fax w/Area Code: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ **OR**  I am Retired **OR**  I am Unemployed

Work Phone w/Area Code: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship:  Self  Spouse  Parent  Other: \_\_\_\_\_

If patient is a Minor, Parent's Name: \_\_\_\_\_

Parent's Home Phone w/Area Code: \_\_\_\_\_ Work Phone w/Area Code: \_\_\_\_\_

Parent's SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is this work-related?  Yes  No If yes, date of injury? \_\_\_\_\_ Claim #: \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_ at \_\_\_\_\_

NAME

Phone # with area code

Emergency Contact Relationship: \_\_\_\_\_

Who referred you to the office?(full name please) \_\_\_\_\_ Is this your Primary Care Physician?  Yes  No

If referring source is NOT your Primary Care Physician, who is your PCP? (Full name please): \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD(S) FOR COPYING AND COMPLETE THE REQUESTED INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ Phone Number: \_\_\_\_\_

>>Primary Insured's Name: \_\_\_\_\_ >>Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship: \_\_\_\_\_

If this is a group policy, please list Employer: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ Phone Number: \_\_\_\_\_

>>Secondary Insured's Name: \_\_\_\_\_ >>Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship: \_\_\_\_\_

If this is a group policy, please list Employer: \_\_\_\_\_

- I hereby authorize the payment of medical benefits to General & Vascular Surgeons, P.C. for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize General & Vascular Surgeons, P.C. to release any medical information necessary to complete and process my insurance claims.
- I authorize Dr. \_\_\_\_\_ to treat me and to use my personal health information for healthcare operations.

**SIGN HERE: X**

Patient's Signature (If patient is a Minor, must have Responsible Party Signature)

Date

## Billing Policy

The following sets forth the general billing policy of General & Vascular Surgeons, P.C. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of General & Vascular Surgeons, P.C. (hereafter GVS) with current, accurate billing information at the time of check in and to notify GVS of any changes in this information.
- I understand that it is my responsibility to know my specialist copay (which can be different than my Primary Care copayment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that GVS also has a contractual agreement with my health plan to collect copays at the time of service.
- I understand that if I present an insufficient funds check (NSF check) to GVS for payment on my account that I will be charged a \$30 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that there is a \$20 fee to complete disability paperwork associated with my care. GVS will provide a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the \$20 fee (payable prior to completion) is required. This fee is per form.
- I understand that GVS will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is GVS's policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that **THE FEE I AM QUOTED IS AN ESTIMATE** based on 1) anticipated surgery to be performed and 2) current information provided to GVS by my insurance carrier.
- ***I understand that GVS will bill me for any amounts due by me and that I have a financial responsibility to pay these amounts. Payment is due upon receipt of the first statement. The second statement will serve as a final notice.***
- ***If GVS must turn my account to an outside collection service due to my failure to pay, my account will be assessed a service fee of \$35. Further, my credit rating may be affected.***
- I understand that GVS will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

*My signature below confirms that I have read, understood and accepted these policies and my financial obligations as pertains to the physicians of General & Vascular Surgeons, P.C.*

**SIGN HERE: X** \_\_\_\_\_

Legal Signature

\_\_\_\_\_ Date

**X** \_\_\_\_\_

Relationship to Patient, if not Patient Signature