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

Ethnicity:______________________________ Race:_________________________ Primary Language:______________________

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 #:_________________________ **Is this Policy # Unique to the patient (different from the Insured?):**__Yes __No

Group #:_________________________ **Relationship (TO THE INSURED ON THIS POLICY):**__________________________

SECONDARY INSURANCE:____ **Phone Number:**_________________________

>>Secondary Insured's Name:______________________________________ **>>Date of Birth:**________________________

Policy #:_________________________ **Is this Policy # Unique to the patient (different from the Insured?):**__Yes __No

Group #:_________________________ **Relationship (TO THE INSURED ON THIS POLICY):**__________________________

- **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.**
- **I hereby authorize the payment of medical benefits to General & Vascular Surgeons, P.C. for services rendered and authorize GVS to act as my agent relating to services provided with my insurance carrier. I understand that I am financially responsible for any services not covered by my insurance carrier.**

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 I am responsible for all collection fees and/or attorney's fees in collecting my debt.***

- 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