

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: _____

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: _____ Work Phone w/Area Code: _____

Spouse's Name: _____ SS #: _____

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: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? __Yes __No If yes, date of injury? _____ Claim #: _____

How did this injury happen? _____

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.

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

I acknowledge that I have reviewed and/or received a copy of General & Vascular Surgeon, P.C.'s "Notice of Privacy Practices."

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.
- 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. If partial payment will be made on the account, a \$2.00 processing fee will be applied to subsequent statements. If payment is not received prior to the 2nd billing cycle, a \$10.00 administration fee will be assessed to my account. The third statement will serve as a final notice. Failure to respond to statements will result in statement fees each month.***
- ***If GVS must turn my account to an outside service due to my failure to pay, my account will be assessed a fee of 40% of the total amount due (example: if I owe \$100 before being turned to collections, I will owe the agency \$140.00).***
- 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.

X

Legal Signature

Date

X

Relationship to Patient