Lakeside Heart & Vascular Center P.L.L.C.

LHVC

PATIENT REGISTRATION

(PLEASE PRINT)

Patient's Last Name: ______________________ First Name: ______________________ MI: ________

Birth Date: ________________ Age: ________ ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Div Soc. Sec. #:____________________

Local/Mailing Address: ______________________ City: ____________ State: _______ Zip: ___________

Permanent Address: ______________________ City: ____________ State: _______ Zip: ___________

Local/Home Phone #: ______________ Business Phone #: ______________ Cell Phone #: ______________

Employer: ______________________ Address: ______________________

Email: ______________________Occupation: ______________ Driver's License Number: ______________

Primary Care Physician: Phone:

Do you have medical insurance? ☐ YES ☐ NO

Do you have a secondary medical insurance? ☐ YES ☐ NO

If you have two insurance companies, please present both cards so that we may file with your secondary carrier for any benefits due to you.

Primary Insurance Name: ______________________

Claims Address: ______________________

City: ____________ State: __________ Zip Code: _______

Policy #: ______________ Group #: ______________

Subscriber Name: ______________ DOB: __________

Social Security #: ______________ Male or Female

Relation to patient: ______________________

Secondary Insurance Name: ______________________

Claims Address: ______________________

City: ____________ State: __________ Zip Code: _______

Policy #: ______________ Group #: ______________

Subscriber Name: ______________ DOB: __________

Social Security #: ______________ Male or Female

Relation to patient: ______________________

Consent for Treatment and Authorization to Release Information

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize Lakeside Heart and Vascular Center, PLLC to furnish my insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIPAA. I further authorize any holder of medical or other information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this, or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment.

Authorization to Pay Benefits to Provider

I request and authorize those payments for authorized Medicare/Other Insurance company benefits be made directly to Lakeside Heart and Vascular Center, PLLC on my behalf for any services furnished to me by Lakeside Heart and Vascular Center, PLLC who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 11288 0f the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Patient Responsibility

I agree that I am responsible for all charges incurred in this office. If my insurance coverage does not provide full benefits, I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with Lakeside Heart and Vascular Center, PLLC Further, I agree that this visit is not related to a litigation matter as it is my understanding that Lakeside Heart and Vascular Center, PLLC does not see this type of case for evaluations and treatments. If cancellation of my appointment becomes necessary, I will contact Lakeside Heart and Vascular Center, PLLC no later than twenty-four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy that I may be subject to a charge of fifty dollars ($50.00) and such charge is not payable through my insurance. I have read the Lakeside Heart and Vascular Center, PLLC Office Policy Statement and all my financial questions were answered.

Signature: ______________________________ Today's Date: ______________