



# PATIENT INFORMATION SHEET

**Trinity Office** (205) 599-3500  
 880 Montclair Rd, First Floor  
 Birmingham, Alabama 35213

**Brookwood Office** (205) 877-9290  
 2022 Medical Ctr. Dr., Suite 510  
 Birmingham, Alabama 35209

**Women's Cardiovascular Ctr.** (205) 877-8526  
 Women's Medical Plaza  
 2006 Brookwood Med. Ctr. Dr., Suite 104  
 Birmingham, Alabama 35209

**Shelby Office** (205) 621-7935  
 1004 1st Street N, Suite 270  
 Alabaster, Alabama, 35007

**Sylacauga Office** (256) 245-5833  
 Coosa Valley Medical Plaza  
 209 West Spring St., Ste. 104  
 Sylacauga, Alabama 35150

**Talladega Office** (256) 480-6300  
 201 Medical Office Park  
 Talladega, Alabama 35160

**Today's Date:** \_\_\_\_\_

**Account #:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

## PATIENT INFORMATION: PLEASE PRINT

PATIENT NAME: <i>FIRST, MI, LAST</i>			STREET ADDRESS:		
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HOME TELEPHONE:	CELL PHONE:	CITY:	STATE:	ZIP CODE:
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**EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

DATE OF BIRTH:	SEX: M F	MARITAL STATUS: S M D W	RACE:	EMPLOYER NAME:
SOCIAL SECURITY NUMBER:	DISABLED: Y N	EMPLOYED: Y N	EMPLOYER ADDRESS:	
REFERRING PHYSICIAN: <i>Who referred you Today!</i>			EMPLOYER TELEPHONE:	
REFERRING PHYSICIAN TELEPHONE:			HOW DID YOU CHOOSE CVA FOR YOUR CARE:	
PRIMARY MEDICAL DOCTOR (PCP): <i>Your Family doctor!</i>			EMAIL ADDRESS:	
PRIMARY MEDICAL DOCTOR (PCP) TELEPHONE:				

## INSURANCE INFORMATION: PLEASE COMPLETE IN FULL

PRIMARY INSURANCE:	POLICY NUMBER:	GROUP NUMBER:
INSURANCE ADDRESS:	INSURANCE TELEPHONE:	EFFECTIVE DATE:
SUBSCRIBER OR POLICY HOLDER NAME:	SUBSCRIBER DATE OF BIRTH:	SUBSCRIBER SEX: M F
SUBSCRIBER EMPLOYER:	RELATION TO PATIENT: SELF SPOUSE CHILD OTHER	COPAY:

SECONDARY INSURANCE:	POLICY NUMBER:	GROUP NUMBER:
INSURANCE ADDRESS:	INSURANCE TELEPHONE:	EFFECTIVE DATE:
SUBSCRIBER OR POLICY HOLDER NAME:	SUBSCRIBER DATE OF BIRTH:	SUBSCRIBER SEX: M F
SUBSCRIBER EMPLOYER:	RELATION TO PATIENT: SELF SPOUSE CHILD OTHER	COPAY:

PLEASE TURN OVER

Insurance claims are completed without charge as a courtesy to our patients. You are, however, responsible for your bill being paid in full regardless of the status of your insurance claim.

The clinic cannot accept the responsibility for collecting your insurance or negotiating a settlement on a disputed claim. We will be pleased to furnish account information to help you should a problem occur.

Should an insurance payment be received that is less than the physician's usual charge for the services provided, you will be responsible for the difference.

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I requested that any payment under my medical insurance programs be made to the provider of services for any medical services and treatment rendered to me. I also request that the provider of services submit a claim to my insurance carrier for payment and authorize payment directly to the provider of services. I hereby authorize physicians rendering services to release my insurers billing and certain medical information for the purpose of determining eligibility for and payment of charges for services rendered.

I realize that insurance may not pay all costs incurred. I therefore agree to pay the difference or the entire bill if necessary. I also agree to pay all costs of collection, including but not limited to, reasonable attorney's fees.

Accepted and Agreed:

Signature of Patient: \_\_\_\_\_

\_\_\_\_\_

Date

Signature of Responsible Party: \_\_\_\_\_

\_\_\_\_\_

Date

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**\*\*FOR MEDICARE PATIENTS ONLY\*\***

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER**

(Extended Payment Request for Physician Services Applicable to Current and Future Treatment)

Patient Name: \_\_\_\_\_

(Please Print)

Medicare HI Claim Number: \_\_\_\_\_

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cardiovascular Associates, P.C. for any services furnished me by or in the name of Cardiovascular Associates, P.C. I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to Cardiovascular Associates, P.C. for any services furnished to me by the physician in the name of Cardiovascular Associates, P.C.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I recognize that this one-time authorization will permit Cardiovascular Associates, P.C. to submit any Medicare claim, without obtaining any additional signature from me, and will remain in the files of Cardiovascular Associates, P.C. for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by my request.

CARDIOVASCULAR ASSOCIATES, P.C.

Signature of Patient: \_\_\_\_\_

\_\_\_\_\_

Date