

609 Jefferson Davis Highway, Suite 201
Fredericksburg, VA 22401
Phone: 540-666-6181
fax : 877-278-1104

Premier Cardiac and Vascular



PATIENT INFORMATION (Please Print)

Name: _____ Date of Birth: ____/____/____ Age: ____
(Last) (First) (Initial)

(Street) (City) (State) (Zip)

Soc. Sec.#: ____ - ____ - ____ Email: _____ *Required for Patient Portal

Referred By: _____

Primary Care Physician and Office: _____

Demographic Information:

Ethnicity:

- Hispanic or Latino Marital Status: S M D W Preferred Language:
 Not Hispanic or Latino Sex: M F Prefer Not to Answer
 Prefer Not to Report Race:

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

(Street) (City) (State) (Zip)

Preferred Pharmacy: _____

Emergency Contact Person:

(Name) (Relationship) (Phone)

Date of Birth: ____/____/____ Email: _____

Billing Information - Person Responsible for Paying this Bill

Name: _____ Relationship to Patient: _____

(Street) (City) (State) (Zip)

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____ DOB: ____/____/____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____ DOB: ____/____/____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with:



Name of Insurance Company(ies)

and assign directly to Dr. Anita Banerjee for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medicaid/Medigap Authorization

I request the payment authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on behalf to Dr. Anita Banerjee of Premier Cardiac and Vascular for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits for related services.

Signature of Beneficiary, Guardian, or Personal Representative

Date

AGREEMENT/INSURANCE WAIVER

I authorize treatment and agree to pay all fees and charges for such treatment promptly upon presentment thereof. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance. In consideration for the professional services rendered now and, in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus, attorney's fees which are hereby stipulated to be 25% of such outstanding balance whether suit is filed or not; plus, court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned.

The undersigned understands that Medical Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I:

am an active duty member of the U.S. Armed Forces

am not an active duty member of the U.S. Armed Forces

Signature

Date

Dear Patients,

PREMIER CARDIAC AND VASCULAR REQUIRES 24 HOURS NOTICE WHEN CANCELING OR RESCHEDULING YOUR APPOINTMENT.

PLEASE BE ADVISED THAT WITHOUT PROVIDING THE PROPER NOTICE AND NO-SHOW A \$25 FEE WILL BE CHARGED TO YOUR ACCOUNT.

COMMUNICATIONS WITH YOU

You agree, in order for us to service our account or to collect any amounts you may owe, we, our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing applicable. You agree that we or our assignees, may for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and assignees third party(s).

Signature

Date

HIPAA

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of PREMIER CARDIAC AND VASCULAR Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Signature

Date

Patient Name (Type or Print)