Heart & Vascular Associates, LLC
Vinay Sanghi, MD | Meredith Shamas, NP-C
We Care!
https://cochiseheart.org
Ph - 520-335-2400
Fax -877-669-0381

Patient Information

Name:_____DOB: _/_/_____Gender: M / F

Social Security Number_____Email Address:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____
Street City State ZIP

Preferred Method of Communication: Home PH / Cell PH / Work PH

Responsible Party (Guarantor) Information

Patient Relationship to Guarantor: _____ Guarantor Name:
Address: _____

_____
Street City State ZIP

DOB: _/_/_____ Social Security Number_____ Gender: M / F

Home Phone:_____Cell Phone:_____Work Phone:_____

Patient Information

Preferred Pharmacy: _____

Preferred Language: _____

Ethnicity/Race:
□ Decline to specify
□ American Indian or Alaska Native □ Hispanic /Latino □ Asian □ Black/African American
□ Native Hawaiian or other Pacific Islander □ White/Caucasian □Other

Primary Care Physician:_____

Next of Kin Name:_____Relationship to Patient:_____
Phone Number:_____
Address:_____
Street City State ZIP

Patient Signature: _____ Date: _____

By signing this document, you acknowledge that the information provided is correct and accurate to the best of your knowledge.

Patient Name: _____ **DOB:** _____

Consent for Treatment: I hereby give my consent for the medical treatment by the physicians or under the direction of the physicians at Heart and Vascular Associates. I may refuse or withdraw consent for treatment before treatment is rendered.

Payment Policy: I understand that I am financially responsible for all charges. co payments and deductibles remaining after insurance payments, and all charges not covered by my insurance company. (ies), Medicare or third party payor.

Assignment of Benefits: I assign to the treating physician of HAVA. all payments for medical services rendered to my dependents or myself for serviced filed on my behalf.

Privacy Policy: I hereby acknowledge that I have received the Notice and Privacy Practices for HAVA.

Authorization for Release of Medical Information: I authorize HAVA to release medical information acquired in the course of my, or the above named patient. examination or treatment necessary to process all claims.

Consent for Communications: I give consent to the practice to use my cell phone number regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone is _____

I give consent to receiving emails from the practice regarding treatment, insurance, special promotions, and my account. I understand I can withdraw my consent at any time.

My email address is _____

Consent for Medical Treatment:

I voluntarily consent to medical treatment, and diagnostic procedures by HAVA and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as a result of treatments or examinations.

Assignment of Insurance Benefits:

I guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and HAVA. I understand that I am responsible for any charges not covered by insurance or other forms of benefits. I understand that HAVA can obtain my credit report for review in collection of this debt. In the event that the account is placed with a collection agency or attorney for collection or collected. I shall pay all collection fees. cost, including reasonable attorney's fees. For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

_____ _____

Signature of patient/ Other responsible party **Date:**

(****Because our clinic treats you before we are guaranteed of your insurance coverage, we do require your SSN as an extension of credit for our services in lieu of the alternative of billing you upfront. Your information, as always, will be kept private and secure.)