

Please bring this completed form to your appointment



371 S Broadview ♦ Cape Girardeau, MO 63703

Telephone: (573) 334-6008

Home Phone: \_\_\_\_\_

Alternate Number: \_\_\_\_\_

**Registration** (Please Print)

Patient \_\_\_\_\_

Responsible party (if a minor) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient employed by: \_\_\_\_\_

Business address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business phone: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Do you have medical insurance?  No  Yes If yes, enter insurance information below

Name of primary insurer: \_\_\_\_\_ Date of birth of primary insurer: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of secondary insurer (if any): \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**Assignment and Release**

I request that payment of authorized Insurance/Medi-Gap benefits be made to Cardiovascular Consultants for all services rendered. I authorize any holder of medical information about me to be released to the Insurance Carrier and its agents; any information needed to determine these benefits or the benefits for related services. I am hereby notified that Insurance/Medi-Gap will only pay for services determined to be "reasonable and necessary." If my Insurance Carrier denies services as uncovered benefits or frequency of service, I acknowledge that I have been informed and will assume responsibility.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**Medicare Authorization**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cardiovascular Consultants for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its' agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS 1500 form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date