

Ohio Heart & Vascular Consultants

REGISTRATION FORM

New

Update

Read Thoroughly, Complete ALL Blanks & Please Print Neatly

PATIENT NAME _____
LAST NAME FIRST NAME, MI.

Address _____
STREET CITY ST. ZIP

Phone _____ Martial Status ... **Single / Married / Other**
Area Code HOME Area Code WORK

Social Security No. _____ - - Date of Birth ____ / ____ / ____ Age _____ Sex ... **Male / Female**

Employment Status... **Employed / FT Student / PT Student / None** ... at _____
EMPLOYER / SCHOOL NAME (If Any)

Co-Pay (If Any) \$ _____ Responsible Party _____ Phone _____
Area Code HOME / WORK / CELL

Ref. Phys. _____ Emergency Contact _____ Phone _____
Area Code HOME / WORK / CELL

Dx. _____ Email _____

PRIMARY INSURANCE CARRIER

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ Pt. Relation **Self / Spouse / Child / Other**
LAST NAME FIRST NAME, MI.

Address _____ Date of Birth ____ / ____ / ____ Sex **Male / Female**
STREET ADDRESS

City _____ St. _____ Zip _____ Phone _____
Area Code HOME

** billed at the practice's discretion only **

SECONDARY INSURANCE CARRIER

** not billed for an office visit copay balance **

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ Pt. Relation **Self / Spouse / Child / Other**
LAST NAME FIRST NAME, MI.

Address _____ Date of Birth ____ / ____ / ____ Sex **Male / Female**
STREET ADDRESS

City _____ St. _____ Zip _____ Phone _____
Area Code HOME

Consent for Treatment

I as the patient or legal guardian of, authorize the **Insurance Carrier** to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the **Insurance Carrier**. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

* Payment Terms Noted *

- This practice accepts the UCR fee of participating carriers. In the event of two carriers the higher of the UCR fees will be considered.
- Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees.

X

Signature

Date

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

Visit www.ohioheart.com and click on "Patient Billing & Account Information"
to update above information, view your account, and make payments online.