HEART, RHYTHM & VASCULAR SPECIALISTS OF DAYTON

ANNUAL PATIENT PAPERWORK

First Name: Middle Initial: Last Name:

SSN: Date of Birth: Age:

Gender: M / F Marital Status: Height / Weight:

Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email Address:

Employer: Employer Phone Number:

Emergency Contact: Relationship:

Emergency Phone:

Primary Care Physician:

Referral Source:

Pharmacy:

Authorization to Release information:

I hereby authorize Heart, Rhythm & Vascular Specialists of Dayton to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at my office visit and that fees are collected on the day of the visit. If for any reason it becomes necessary to render collection proceedings, I understand that I am responsible for all treatments, and services received, as well as all legal and collection fees that occur at Buckeye Heart and Vascular institute.

Signature: Date:

PLEASE SIGN ON THE BACK →

HEART, RHYTHM & VASCULAR SPECIALISTS OF DAYTON

CONSENT FOR PURPOSES OF TREATMENT PAYMENT AND HEALTH CARE OPERATIONS

Prior to using or disclosing your protected health information (PHI) to carry out treatment, payment, or health care operations, we are required under federal law to obtain your consent.

I consent to Heart, Rhythm & Vascular Specialists of Dayton using or disclosing my PHI for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill, or conducting health care operations. I understand that if I fail to sign this consent, the physicians, and Heart, Rhythm & Vascular Specialists of Dayton may refuse to provide treatment or care for me.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment and/or payment to health care operations. Heart, Rhythm & Vascular Specialists of Dayton is not required to agree to these restrictions. However, if Heart, Rhythm & Vascular Specialists of Dayton agrees to a restriction that I request, the restriction is binding on Heart, Rhythm & Vascular Specialists of Dayton and the physicians of Heart, Rhythm & Vascular Specialists of Dayton.

I have the right to revoke this consent, in writing, at any time, except to the extent that Heart, Rhythm & Vascular Specialists of Dayton or the physicians Heart, Rhythm & Vascular Specialists of Dayton has taken action in reliance of this consent.

I understand I have the right to review Heart, Rhythm & Vascular Specialists of Dayton notice of privacy practices prior to signing this consent form. The notice of privacy practices gives a more complete description of the permissible uses and disclosures of my PHI. The notice of privacy practices is available upon request.

Heart, Rhythm & Vascular Specialists of Dayton reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised copy of privacy practices by calling the office and requesting a copy be sent by mail or given at the time of my appointment.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms set forth in this consent.

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Signature of Patient or Personal Representative   Date

____

Printed Name of Patient or Personal Representative

HEART, RHYTHM & VASCULAR OF SPECIALISTS OF DAYTON

INSURANCE INFORMATION

Primary Insurance: ____

Policy Number: _______________________________ Group Number: ___________________________

Policy Holder's Name: ____

Policy Holder's Date of Birth: ___________________________ SSN: _____________________________

Policy Holder's Relationship to Patient: ____

Secondary Insurance: ____

Policy Number: _______________________________ Group Number: ___________________________

Policy Holder's Name: ____

Policy Holder's Date of Birth: ___________________________ SSN: _____________________________

Policy Holder's Relationship to Patient: ____

Tertiary Insurance: ____

Policy Number: _______________________________ Group Number: ___________________________

Policy Holder's Name: ____

Policy Holder's Date of Birth: ___________________________ SSN: _____________________________

Policy Holder's Relationship to Patient: ____

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for medical services.

1. Heart, Rhythm & Vascular Specialists of Dayton works with a variety of medical insurance plans.
    - Bring all Insurance cards with you to every visit.
    - Be prepared to pay all co-pays at each visit – We accept cash, check, and credit.
    - For medical care NOT covered by your insurance, payment is due at the time of service.
2. If you have insurance that we do not accept, we are happy to submit a claim upon your request, payment is due at time of service.
3. If you are unable to pay for necessary medical care, you may be eligible to financial assistance. It is your responsibility to inform us prior to your visit.
4. It is your responsibility to bring any referrals with you at or prior to your visit. If you do not have a referral, your visit may be rescheduled, or you may be held financially responsible.
5. If you have a question about your insurance, we are happy to assist you. Specific coverage questions should be directed to your Insurance company's member service department.
6. If you fail to make a payment in full to the services that are rendered to you, your outstanding balance will be sent to a collection agency. You will be responsible for any fees assessed by the collection agency.

Heart, Rhythm & Vascular Specialists of Dayton Firmly believes that a good physician/patient relationship is based on proper communication and understanding. Questions about any financial arrangements should be directed to our billing service.

Your signature below indicates that you have read, fully understand, and agree to this financial policy.

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Patient Signature　　　　　　　　　　　　　　　　　　　　Date

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Patient's Printed Name