Interventional Cardiac Consultants, P.L.C.

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ANNUAL UPDATE FORM

Patient Name: ____

Address: ____

Home Phone: ______________________Cell Phone: ______________________Email Address____________________________

Social Security Number: ______________Date of Birth: _____________Marital Status: Single __Married __Divorced __Widowed __

Spouse Name: _________________________ Social Security #: __________________________

Primary Insurance: __________________________________ Secondary Insurance: ______________________________________

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care options) with:

Please list the family members or significant others, if any, whom we may inform about your medical condition in case of an emergency:

Name: ________________________________ Relationship: ____________________ Phone #: ___________________

Name: ________________________________ Relationship: ____________________ Phone #: ___________________

Name: ________________________________ Relationship: ____________________ Phone #: ___________________

Signature: ____________________________ Date: ____________________________________

PRIVACY NOTICE

I have received a copy of Interventional Cardiac Consultants, P.L.C.'s office privacy policy notice.

Patient Name (print): ____________________________ SS#: ____________________________________

Signature: ____________________________________ Date: ____________________________________

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/insurance benefits be made either to me, or on my behalf, for any services furnished by Interventional Cardiac Consultants, P.L.C. I authorize any holder of medical information about me to be released to CMS/Insurance Carriers and its agents. Any information needed to determine these benefits or benefits related to services may be released.

I hereby authorize Interventional Cardiac Consultants, P.L.C. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for elated services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to Interventional Cardiac Consultants, P.L.C. for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: ____________________________________ Date: ___________________