Interventional Cardiac Consultants, PLC

Carlos J. Bayron, M.D., F.A.C.C., F.S.C.A.I | Luis Annoni-Suau M.D., F.A.C.C. | Rudy E. Kunhardt, M.D. |
Raul A. Jimenez, M.D., F.A.C.C. | Abdur Rahim, M.D., F.A.C.C. | Patrick A. Cambier, M.D., F.A.C.C., F.S.C.A.I. |
Rafael Sanchez-Ponce, M.D., F.A.C.C. | Candice Kouhounian, MSN ARNP-C

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: _____