Dublin - Macon Cardiology, P.C.
Patient Information

Date:_____

Last Name:_____First Name:_____MI:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone #: (_____)-_____-_____ Work Phone #: (_____)-_____-_____

Social Security #:_____ Date Of Birth:_____/_____/_____

Employer:_____ Employed: Full Time Part Time Sex: M F

Occupation:_____ Marital Status: Married Single Widowed Other

Spouse's Name:_____*Spouse's Occupation*:_____

Spouse's Date of Birth:_____/_____/_____ *Spouse's Social Security #:* _____

Spouse's Employer:_____ *Employed*: Full Time Part Time

Insurance Information

Primary Insurance:_____

Policy #:_____Group #:_____

Subscriber:_____Relation to Patient:_____

Secondary Insurance:_____

*Policy #:*_____*Group #:*_____

*Subscriber:*_____*Relation to Patient:*_____

Emergency Contact

Name:_____Date of Birth:____/____/____

Address:_____City/State:_____Zip:_____

Home Phone #: (_____)-_____-_____ Work Phone #: (_____)-_____-_____

Relation to Patient:_____

Dublin - Macon Cardiology, P.C.

Acknowledgement of Financial Responsibility

The information provided is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services at the time services are rendered. I authorize payment of medical benefits to Dublin-Macon Cardiology, P.C., when claim forms are filed upon my behalf for office visits, procedures, or hospital admission and care. I understand that I am financially responsible for any charges not covered by my medical insurance plan(s).

Payment is required at time of service unless prior arrangement has been made with our business office.

Signature of Patient / Parent / Legal Guardian Date

Dublin - Macon Cardiology, P.C.

Dear Patient,

Your medical insurance coverage is part of a PPO (preferred Provider Organization), or HMO (Health Maintenance Organization), or Standard Insurance, Standard Medicare, or POS (Point of Service Plan). It is your responsibility to provide our office with a copy of your insurance card(s) so that we mat verify your eligibility and benefits, and also so that we may submit claims to the insurance company on your behalf. We have no control over the terms of your insurance contract, and questions regarding your coverage should be addressed to your employer and/or insurance company.

You are financially responsible for certain charges at the time of each office visit - with the exception of certain procedures. You may be responsible for payment of any, or all of the following items:

1: DEDUCTIBLE	Some plans require that you pay a deductible (a certain dollar amount) before insurance will cover any medical expense.
2: CO-PAYMENT	This is a set dollar amount (usually $5 - $25), or a percentage (usually 10% - 20% of total charges), that you are required to pay at each office visit.
3: CO-INSURANCE	This is the percentage of the charges that you pay in addition to any deductible. For example, if insurance pays 80% of total charges, you will pay 20 %.
4: NON-COVERED	These may include office visits, medical supplies, laboratory or diagnostic testing. You are responsible for payment of any charge that your insurance considers to be a non-covered service.

In the event that you "overpay" us, we will issue you a prompt refund after we receive payment from your insurance carrier and the explanation of benefits has been reviewed.

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of my Medicare benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to Dublin-Macon Cardiology for services described. **I understand that I am responsible for payment regardless of Insurance coverage.**

Patient's Name _____

Patient's Signature _____ Date _____