Sanjaykumar Patel, MD, FACC

Board Certified in Interventional Cardiology

INSURANCE VERIFICATION FORM

TO THE PATIENT: THE FOLLOWING INFORMATION IS REQUIRED IN ORDER FOR THE OFFICE TO FILE YOUR INSURANCE. FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN YOU BEING REQUIRED TO PAY FOR YOUR VISIT IN FULL AT THE TIME OF SERVICE.

Patient Name: _____ Patient DOB: ____/____/_____
(First, Middle, Last) Must Match on Insurance Card
SSN: _____/_____/_____
Home/Cell Phone Number: (_____) ____-_____ Email: _____
(Please provide Cell phone and email to get access to patient portal to get access to your chart online)
Home/Mailing Address:
_____

ETHNICITY: Hispanic / Non-Hispanic , **PREFERRED LANGUAGE**: English / Spanish , **RACE** : American Indian or Alaska Native, Asian , Black or African American, Native Hawaiian or Other Pacific Islander, White

EMERGENCY CONTACT INFORMATION (Next of Kin)
Name _____ *Relationship* _____ *Cell Phone* _____

If Patient is not Primary Policy Holder for Insurance: Please Provide Following Information

PATIENT RELATIONSHIP TO Policy Holder: SELF / SPOUSE / CHILD / OTHER

PRIMARY POLICY HOLDER INFORMATION IF DIFFERENT THAN PATIENT:
***NAME:*_____ *D.O.B:* _____/_____/____ *S.S. #*_____-____-_____**
HOME ADDRESS:_____
Phone Number: (_____) ____-_____ Employer : _____

NAME OF PRIMARY INSURANCE CARRIER:
_____
*GROUP NO:*_____
*I.D. NUMBER:*_____
*EFFECTIVE DATE:*_____
(EFFECTIVE DATES MUST BE GIVEN)

NAME OF SECONDARY INSURANCE CARRIER:
_____
*GROUP NO:*_____
*I.D. NUMBER:*_____
*EFFECTIVE DATE:*_____
(EFFECTIVE DATES MUST BE GIVEN)

ARE YOU COVERED BY MEDICARE?_____ MEDICARE #:_____RAILROAD?____
ARE YOU COVERED BY MEDICAID?_____

INSURANCE COMPANY MAILING ADDRESS:
_____
_____
_____

INSURANCE COMPANY MAILING ADDRESS:
_____
_____
_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES AND DISCLOSURE OF OWNERSHIP

Please carefully review the information contained in this notice. This is furnished to all patients of Comprehensive Cardiovascular Care of the Woodlands, P.A.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ ___/___/_____ _____

Signature of Patient or Personal Representative **Date Printed** **Name**

RELEASE OF INFORMATION

I authorize Comprehensive Cardiovascular Care of the Woodlands, P.A. to release my private healthcare information to the following family members if needed:

_____ _____

Printed Name **Printed Name**

CONSENT FOR TREATMENT

I consent for medical services and treatment from the physician and staff of Comprehensive Cardiovascular Care of the Woodlands, P.A.

_____ ___/___/_____

Signature of Patient or Personal Representative **Date**

ASSIGNMENT OF BENEFITS AND PAYMENT POLICY

I authorize payment of medical benefits from my insurance carrier to the physicians of Comprehensive Cardiovascular Care of the Woodlands, P.A. I understand if I do not assign benefits, I will be responsible to for services in full at the time services are rendered. Co-payments, co-insurance, or deductibles require payment at the time of service. If you have insurance coverage with a managed care plan, it is your responsibility to ensure we are a contracted physician.We refer lab work to numerous laboratories. It is your responsibility to ensure they are a contracted lab on your plan. If your insurance requires a referral to see a specialist, it is your responsibility to make sure there is a current referral on file with our office. I have read and understand the above policy and also understand I am responsible for timely payment of my account.

_____ ___/___/_____

Signature of Patient or Personal Representative **Date**

You should be aware that your physician may have various affiliations or ownership interests in the below facilities. You are hereby advised that if you wish, you have the right to use a different healthcare facility which we can provide you a list of at your request. You will not be treated differently by your physician if you choose another healthcare facility.

You are entitled to make informed decisions regarding your medical care. Pursuant to 42 C.F.R./489.3 – You are hereby notified that CHI St. Luke's Lakeside Hospital meets the federal definition of a physician owned hospital. A list of hospital physician owners/investors is available upon request from the hospital and includes : Dr. Sanjaykumar Patel as a physician owner.