PATIENT REGISTRATION | **John V. White, M.D., LLC**

DATE ________________ | **Vascular Surgery**

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME

DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ S ☐ M ☐ W ☐ Sep ☐ D

HOME ADDRESS – STREET	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

PATIENT EMPLOYER NAME	WORK PHONE NUMBER

PATIENT EMPLOYER ADDRESS – STREET	CITY	STATE	ZIP CODE

RESPONSIBLE PERSON – GUARANTOR INFORMATION

RESPONSIBLE PERSON LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP

HOME ADDRESS – STREET	CITY	STATE	ZIP CODE

GUARANTOR HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER

GUARANTOR EMPLOYER NAME

GUARANTOR EMPLOYER ADDRESS – STREET	CITY	STATE	ZIP CODE

INSURANCE INFORMATION

INSURANCE NAME – PRIMARY	POLICY HOLDERS NAME	RELATIONSHIP

INSURANCE ID NUMBER	GROUP NAME	GROUP NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE NAME – SECONDARY	POLICY HOLDERS NAME	RELATIONSHIP

INSURANCE ID NUMBER	GROUP NAME	GROUP NUMBER

INSURANCE COMPANY ADDRESS

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT LAST NAME	FIRST NAME	RELATIONSHIP	PNONE NUMBER

ADDRESS – STREET	CITY	STATE	ZIP CODE

As a courtesy to our patients, we accept most insurance plans and submit claims to these plans on your behalf. In order to do this efficiently, it is important that we have accurate and complete information regarding your insurance coverage. Additionally, it is important that all of your insurance plans pre-authorization and referral requirements are met prior to the provision of services

It is the patient's responsibility to pay for all provided services that are not covered by insurance. This includes any amount denied or not covered by your insurance plan. If your insurance denies payment in part or in full, you will be billed the balance.

Outstanding balances are billed monthly and payment is due upon receipt. Account balances that have not been paid within three (3) consecutive cycles will be turned over to a licensed collection agency.

RESPONSIBILITY FOR PAYMENT

In consideration of services to be rendered, the undersigned agrees as patient or guarantor, to pay for all services provided including any deductible, co-payment, or charges not covered by third party payors.

In consideration of services, I hereby assign and authorize direct payment to the treating physician of any insurance, health plan, or third party payor benefits otherwise payable to me or on my behalf for services rendered.

I request that payment of authorized Medicare benefits (if applicable) be made on my behalf for physician services rendered to me and I assign such benefits to the physician rendering the same.

RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician or other healthcare provider who may treat me to release any and all pertinent information contained in my medical records to:

1) **Entities involved in billing and collection and third party payors responsible for payment of patient charges including, but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies, or intermediaries representing the above.**

2) **Referring and follow-up healthcare providers for purposes of continuity of care.**

I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patient's behalf. I understand this consent has no expiration date.

Patient Name (printed) ____ Date ______________

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Patient Signature (or parent/legal guardian/patient representative)