Rao Heart & Vascular

Date: _____

PATIENT INFORMATION RECORD (Please print or write legibly)

Last Name _____ First Name _____ Middle Initial _____

Preferred Name _____ Date of Birth _____ SSN# _____

Marital Status _____

Sex ☐ Male ☐ Female Primary Language ☐ English ☐ Spanish Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino Race ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Other

Patient's Mailing Address _____ City _____

State _____ Zip Code _____ Email _____

Home Phone (_____)_____Cell Phone (_____)_____ Work Phone (_____)_____

Employer _____ Occupation_____

Employer Address_____

Preferred Pharmacy _____Family Doctor_____

Referring Doctor _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone (_____)_____

Address _____ Relation _____

I hereby authorize my healthcare professional to evaluate and render treatment to me. This authorization will be effective until revoked in writing by me or my legal representative.

I authorize my physician, or employees and/or agents to discuss my medical/billing information with me and anyone I have designated as a personal representative. I authorize use of an appointment reminder system via phone or email. I give prior express consent to contact me by sending text messages (which could result in charges to me from my carrier) or e-mails, using any email address or phone number, for the purpose of treatment, insurance, appointments, and/or payment.

I have been made aware and understand that the physicians/nurses may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I authorize the release of any medical or other information necessary to process my medical claims.

I acknowledge that I have been offered/received the Notice of Privacy Practices.

Signature _____ Date _____

TURN OVER TO CONTINUE ON BACK

Financial Policy

Patient Name: _____DOB:_____Date:_____

The Physicians at Rao Heart & vascular, LLC/Affiliated specialties appreciate your confidence in choosing us to provide for your health care needs. Our services imply a financial responsibility on your part – an obligation to ensure payment in full of our fees. We would like to share our financial policies with you since a clear understanding of our financial policies is an important component of our professional relationship.

Methods of Payment

We will bill your insurance as a courtesy to you with a copy of your current insurance card, which must be presented at each visit. If you do not have your insurance card, payment is due in full at the time of service. For your convenience, we accept cash, checks, and credit cards. Please note that there is a $35 charge for checks returned by the bank.

Participation with Insurance & Medicare

Rao Heart & Vascular/affiliated specialties participate with Medicare, as well as many PPO plans, which means that we accept the assignment of benefits. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. If we do not have a contract with your insurance company, you are responsible for payment in full and considered to be self-pay. Payment is due at the time of service; we will supply you with a superbill to submit to your insurance company for direct reimbursement.

Medicare: As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance with a company whom we are contracted, we will bill your secondary insurance for you. Any remaining balance will be billed to you.

PPO Plans: As a component of our contracts, we collect co-payments and co-insurance for every visit. If you have not met your deductible, we will as that you pay what remains of your deductible. If you have a remaining balance after your insurance plan processes your claim, you will receive a statement from us. Payment is expected within 10 days of the statement date.

No Show Fees

Please note that we may find it necessary to charge a fee of $30 if you do not give at least a 24-hour notice when cancelling your appointment/test/procedure or surgery, or if you do not show up for your appointment/test/procedure or surgery. Cancellation in advance allows your appointment time to be offered to other patients who may have urgent healthcare needs.

Our Fees

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates. Co-payments, co-insurance, and deductibles, or unpaid balances are due at the time of service. If the co-pay/co-insurance is not paid in full of check-in, a fee of $3.00 may be added to your account for each bill sent.

Fees for Completion of Forms

There is a minimum charge of $20 to complete forms such as disability or FMLA forms.

Refunds

If you are due a refund, it will be refunded to you within 60 days of discovery by us if you have a zero balance.

Collection Fees

I agree that the fees charged for services provided by Rao Heart & Vascular/affiliated specialties constitute a valid and lawful debt obligation. If I fail to pay the debt and my account is referred to a collection agency or an attorney, I agree that, in addition to the debt for the services provided, I will be responsible for the payment of a collection agency fee of 33% of the debt as well as any attorney's fees, court costs and expenses. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama, and any other State. Additionally, if I reside in Florida, I agree to waive my rights to an exemption that would prohibit a wage garnishment should become necessary to secure payment of any outstanding balance. By signing below, I consent to the foregoing terms and affirmatively acknowledge that I have read the forgoing before signing below.

Contact by Cell Phone regarding balances

By signing below, I agree for Rao Heart & Vascular/affiliated specialties to service my account or to collect monies I may owe, I may be contacted by telephone at any number associated with my accounts, including wireless telephone numbers. Rao Heart & Vascular/affiliated specialties may also contact me by sending text messages (which could result in charges to me from my carrier) or emails, using any email address I provide to them. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I have read the Financial Policies as stated and I understand that it is my responsibility to provide valid insurance information at each visit, as required by my insurance provider. I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of government benefits either to myself or to the party who accepts assignment on my medical claims. I authorize payment of medical benefits to Rao Heart & Vascular/affiliated specialties.

_____ _____

Signature of Patient or Legal Guardian Date