Last Name: _____________ **First Name**: _______________ MI____ Date of Birth:___________
Address:_________________________ City:____________ State:____ Zip Code:____________
Phone Number (Cell): ______________________ E-Mail Address:_________________________
Gender: M , F || SSN: ______________ || Driver's License: ___________________
Primary Care Provider: ____
Referring Provider: ____
How were you referred to us (google, newspaper, other doctor): _________________________

Employment Information
Occupation: _____________________ Employer: _____________________________________
Work Address: ____
Work Phone: ____

Insurance (circle): BC/BS Medicare Medicaid/Public Aid Other: _________________________
Policy Number: ____
Group # (BC/BS only) : ____

Authorization for Claims Payment and Reviews:
1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits (“Insurance Plan(s)”) to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Stat! Cardiologist Inc (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Stat! Cardiologist Inc. (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care. 2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Stat! Cardiologist Inc. for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance. 3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

Patient Signature: ________________________________ Date: _____________________________

- **No show fees $35(must cancel 24 hrs in advance)**
- **Procedure cancellations(Echo, Treadmill): $75**