ISLAND CARDIOVASCULAR ASSOCIATES, L.L.P.

Patient Name:_____ **Age/Sex:**_____ **Date of Birth:**_____

Address:_____ **SS No:**_____

City:_____ **State:**_____ **Zip:**_____

Home Phone No.:_____ **Work Phone No.** _____ **Cell Phone No.**_____

Marital Status: **Single**_____ **Married**_____ **Divorced**_____ **Separated**_____ **Widow**_____

Spouse's Name:_____ **DOB:** _____

Patient's Employer's Name:_____ **Address:**_____

City:_____ **State:**_____ **Zip:**_____

Referring Physician Name and Address:_____

Billing: (Please complete if person responsible for bill is other than patient.)
Name:_____ **SS No.:**_____ **Relationship to Patient:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Employer:_____ **Address:**
Please give us all pertinent information regarding your insurance coverage. If you have more than one carrier, supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. If your coverage is contingent on a second opinion or pre-admission approval, it is your responsibility to inform us.

***Primary Carrier Name:**_____ **ID No:**_____
Insured (Name on ID Card):_____ **Effective Date:** _____
Relationship to Patient: **Self**_____ **Spouse**_____ **Child**_____ **Other**_____
Group Number:_____ **or Company Name:**_____
***Secondary Carrier Name:**_____ **ID No:**_____
Insured (Name on ID Card):_____ **Effective Date:**
Relationship to Patient: **Self**_____ **Spouse**_____ **Child**_____ **Other**_____
Group Number:_____ **or Company Name:** _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE
Name of Beneficiary:_____ **HI Claim No.:**_____

I request that payment of authorized Medicare benefits be made directly to Island Cardiovascular Associates (Drs. Ganguly/Geller/Malhotra/Rosenband/Cohen/Khan) for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

I am aware that my insurance may have certain guidelines I must follow in the event that my condition may require surgery and that I have been for non-emergency tests performed outside of the frequency prescribed by my physician. I agree to be personally responsible for payment of any denied claims. I acknowledge that I have received a copy of the notice of privacy practices for Island Cardiovascular.

Patient Signature: _____ Dated:_____