SOUTHERN VASCULAR CLINIC

INSERT PATIENT LABEL HERE

PATIENT INFORMATION SHEET

Name:_____ Date of Birth:_____/_____/_____

Preferred name:_____ Age:_____ Gender: _____M _____F

Home Phone Number: _____ Work: _____ Cell: _____

Address:_____ Apt #_____

City: _____ State: _____ Zip Code:_____

Social Security Number :_____-_____-_____ Email Address:_____

Contact Person:_____ Relationship: _____

Primary Contact Number: _____ Secondary: _____

Employer: _____ Phone Number: _____

BILLING ADDRESS IF THE PATIENT IS A MINOR

Parents or guardian information if patient is a minor or other legal guardian:

Name:_____ Date of Birth: _____/_____/_____

Home Phone Number: _____ Work: _____ Cell: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code:_____

Social Security Number: _____-_____-_____ Email Address:_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, check, MasterCard, or Visa. In the event of hospitalization or minor procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Please check the rules of your insurance company.

Additionally, I understand that if my account becomes DELIQUENT after 90 days, I will be DISCHARGED from the practice and will be responsible for all fees including Legal or other costs incurred in the collection of the account.

Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes the doctor or release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed. I have received the notice of privacy practices.

Patient/Guardian Signature:_____ Date:_____