HEART GROUP of the Eastern Shore

- ❑ Bay Minette
- ❑ Fairhope
- ❑ Robertsdale

- ❑ Michael S. Pursley, M.D., F.A.C.C.
- ❑ Jack W. Brand, Jr., M.D., F.A.C.C.

HAVE YOU BEEN TREATED BY HEART GROUP OF THE EASTERN SHORE?	
❑ YES	❑ NO
IF YES, WHEN?	

PATIENT INFORMATION (PLEASE PRINT)

ACCOUNT NUMBER	CHART NUMBER	PHYSICIAN

PATIENT'S NAME (LAST) (FIRST) (MIDDLE)				TELEPHONE
ADDRESS	CITY	STATE	ZIP	
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	TELEPHONE ( )	
SEX / RACE / MARITAL STATUS S M D W	BIRTHDATE	SOCIAL SECURITY NUMBER		
SPOUSE'S NAME	SPOUSE'S DOB	SOCIAL SECURITY NUMBER		
ADDRESS	CITY	STATE	ZIP CODE	

SPOUSE'S EMPLOYER	PHONE	SPOUSE'S OCCUPATION
EMERGENCY CONTACT OTHER THAN SPOUSE	HOME PHONE	WORK PHONE
ADDRESS	CITY / STATE	ZIP CODE

ALLERGIES:

PERSON RESPONSIBLE FOR BILL² (IF OTHER THAN PATIENT)

NAME (LAST) (FIRST) (MIDDLE)			DATE OF BIRTH	TELEPHONE ( )
ADDRESS	CITY	STATE	ZIP CODE	
EMPLOYER	SOCIAL SECURITY NUMBER	OCCUPATION	HOW LONG EMPLOYED?	TELEPHONE

INSURANCE INFORMATION (PRIMARY POLICY)

INSURANCE COMPANY	CONTrACT #	GROUP #		
POLICY HOLDER/SUBSCRIBER	RELATIONSHIP TO PATIENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S ADDRESS	SUBSCRIBER'S EMPLOYER

INSURANCE INFORMATION (SECONDARY POLICY)

INSURANCE COMPANY	CONTrACT #	GROUP #		
POLICY HOLDER/SUBSCRIBER	RELATIONSHIP TO PATIENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S ADDRESS	SUBSCRIBER'S EMPLOYER

REFERRING PHYSICIAN OR PRIMARY CARE DOCTOR

PHYSICIAN NAME: _____ DATE COMPLETED

ADDRESS: _____

CITY / STATE / ZIP CODE: _____

PHONE NUMBER: _____

PLEASE TURN OVER AND SIGN BACK OF FORM

Insurance claims are completed without charge as a courtesy to our patients. You are, however, responsible for your bill being paid in full regardless of the status of your insurance claim.

The clinic cannot accept the responsibility for collecting your insurance or negotiating a settlement on a disputed claim. We will be pleased to furnish account information to help you should a problem occur.

Should an insurance payment be received that is less than the physician's usual charge for the services provided, you will be responsible for the difference.

I request that any payment under my medical insurance programs be made to the provider of services for any medical services and treatment rendered to me. I also request that the provider of services submit a claim to my insurance carrier for payment and authorize payment directly to the provider of services. I hereby authorize physicians rendering services to release to my insurers billing and certain medical information for the purpose of determining eligibility for and payment of charges for services rendered.

I realize that insurance, workmen's compensation and / or liability claims may not pay all costs incurred. I therefore agree to pay the difference or the entire bill if necessary. I also agree to pay all costs of collection, including,but not limited to, reasonable attorney's fees.

Accepted and Agreed:

Signature of Patient:_____ _____
Date

Signature of Responsible Party:_____ _____
Date

"FOR MEDICARE PATIENTS ONLY"

STATEMENT OF PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER
(Extended Payment Request For Physicians Services Applicable
to Current and Future Treatment)

Patient Name:_____
(please print)

Medicare HI Claim Number:_____

I certify that the information given by me in applying for a payment under Title XVII of the Social Security Act is correct. I request the payment of authorized Medicare benefits be made either to me or on my behalf to Heart Group of the Eastern Shore for any services furnished me by or in the name of The Heart Group, P.C.. I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to Heart Group of the Eastern Shore for any services furnished to me by the physician in the name of Heart Group of the Eastern Shore

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 recognize that this onetime authorization will permit Heart Group of the Eastern Shore to submit any Medicare claim, without obtaining any additional signature from me, and will remain in the files of Heart Group of the Eastern Shore for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by my request.

HEART GROUP OF THE EASTERN SHORE

Signature of Patient:_____ _____
Date