California Cardiovascular and Thoracic Surgeons

168 North Brent Street, Suite 508 Ventura, CA 93003
Telephone (805) 643-2375 Fax (805) 643-3511

Your assistance in completing the following information thoroughly and accurately will allow us to provide you with the best care. We appreciate your cooperation and understanding. Please complete, sign and date all forms. Thank you for your help in providing this important information.

PATIENT INFORMATION

Name _____ Date of Birth _____
SS # _____ Marital Status: _____ Sex: _____
Home Address _____ City _____
State _____ Zip _____ Email _____
Mailing Address (if different) _____
_____
Home Telephone # (____)_____ Mobile/Cell phone # (____)_____
Employer Phone # (____) _____ Which phone do you prefer we use? _____
Preferred Language: English _____ Spanish _____ Other _____
Ethnicity (not required) _____ Race (not required) _____
Employment Status: Employed____ Retired____ Other____ Occupation _____
Employer Name and Address: _____
_____
Do you have an "Advanced Directive" also known as a "Living Will" or a "Durable Power of Attorney for Health Care"? Yes_____ No_____ (If yes, please provide us with a copy for our records)

PHYSICIAN INFORMATION (Name and Address)

Referring Physician: _____
Primary Care Physician: _____
Other Treating Physicians: _____
_____

SPOUSE INFORMATION (or if patient is a Minor, enter responsible party information)

Name _____ Date of Birth _____
Home Address _____ City _____
State _____ Zip _____ Telephone # (_____) _____
Employer Name and Address _____
_____
Work Phone # (_____) _____ Cell Phone # (_____) _____

EMERGENCY INFORMATION

Please provide the nearest Adult relative, not your spouse who is **not** living with you

Name _____ Relationship _____
Address _____ City _____
State _____ Zip _____ Telephone # (_____) _____

INSURANCE INFORMATION

Please bring your Insurance card(s) to your appointment and our receptionist will take a copy of it

Medicare: Yes_____ No_____ If yes, Medicare ID# _____
Is Medicare your primary Insurance? Yes_____ No_____
Medi-Cal: Yes _____ No_____ If yes, Medi-Cal ID# _____

*Primary Insurance Company **or** your Medicare Supplement:*
Name of Company _____ Telephone (_____) _____
Identification/Policy # _____ Group # _____
Claims Address _____ City _____
State _____ Zip _____
Subscriber (Policyholder's) Name _____
Subscriber's Social Security Number _____ Subscriber's DOB: _____

*Secondary Insurance Company **or** your Medicare Supplement:*
Name of Company _____ Telephone (_____) _____
Identification/Policy # _____ Group # _____
Claims Address _____ City _____
State _____ Zip _____
Subscriber (Policyholder's) Name _____
Subscriber's Social Security Number _____ Subscriber's DOB: _____

SIGNATURE

The above information is true and correct to the best of my knowledge.

_____ _____
Signature of Patient or Responsible Party Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I may be entitled from an insurance plan(s) to CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of benefits.

_____ _____

Patient's Signature/ Insured's Signature Date

MEDICARE ASSIGNMENT ***If you have Medicare, please sign the following*

I request that payment of authorized Medicare benefits may be made on my behalf to CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on the CMS1500 or any electronically generated claim form, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient's Signature/ Insured's Signature Date

If the signature is other than the patient's, please write the patient's name followed by the signature of the person signing, and complete the following:

Name and Address of Signing Party_____

_____

Relationship to the patient _____

Reason the patient could not sign _____

CONSENT TO RELEASE INFORMATION

I hereby authorize CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS to furnish information to any referring physician, agency, or insurance company I have listed in the Patient Information form.

_____ _____

Signature of Patient or Responsible Party Date

INSURANCE AND FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to making health care less stressful and more effective by summarizing our policies and clarifying your financial responsibilities in advance**. Please read thoroughly and sign where indicated.** We are happy to answer any questions you may have.

INSURANCE INFORMATION

CONTRACTED PRIVATE INSURANCE: We contract and/or participate with many private insurance programs. If you are a member of one of the plans we contract with, we will accept payment at the level allowed by your program (except if you have multiple insurances), although you will be responsible for any deductible, co-payment or co-insurance required by your plan. Necessary adjustments to our billed charges will be made after payment is received from the payer. Please check with our business office staff to verify that we are contracting with your program.

OTHER PRIVATE INSURANCE: We will assist you by billing your insurance company. However, you are responsible for all charges billed to you. We reserve the right to ask you to pay a deposit before services are rendered. We find that most insurance plans only cover a portion of your medical expenses and you will have some balance to pay.

NON-CONTRACTED PRIVATE INSURANCE: If you have an insurance plan that we *do not* contract with, our group is considered to be "Out of Network" and this will most likely affect your benefits and how your claim is processed and paid. Please check with your insurance company for how your particular plan processes these claims. In cases where we are not contracted with your plan, we will request payment before or at the time services are rendered. As a courtesy we will submit the claim on the patient's behalf to the insurance company.

MEDICARE PATIENTS: Our office is a participating Medicare physician group. As such, Medicare patients will only be required to pay the difference between what Medicare allows and the amount paid by Medicare, which is the Medicare co-insurance and deductible. Necessary adjustments to our billed charges will be made after payment by Medicare is received.

MEDI-CAL PATIENTS: Our office accepts Medi-Cal patients and Medi-Cal coverage on a limited basis. You may wish to discuss your individual case with our business office to determine if we can accept you and/or your coverage for the month of service. You are responsible for any Share-Of-Cost due for the month of service before services are rendered.

CO-PAYMENTS: If your health plan requires a co-payment, please be prepared to make the appropriate payment at the time of service.

FINANCIAL RESPONSIBILITY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and it is not a substitute for payment. You are ultimately responsible for the bill. Some companies pay fixed allowances for certain procedures; others pay a percentage of charges. It is your responsibility to pay any deductible, co-payment, co-insurance and any balance not paid by your insurance that we are not required to adjust. It is your responsibility to provide us with all the information we may need to properly submit claims on your behalf. This includes providing us with accurate and current insurance information. You are responsible to inform our office if you have any updates or changes to your insurance plan and/or coverage. We will work with your insurance company within reason. However, you are responsible for charges for services you incur.

A cancellation fee of $25.00 will be charged for any appointment missed, or cancelled with less than a 24 hour notice.

All balances are due within 30 days of the statement showing the balance. You may pay by cash, check, Visa or MasterCard. If your account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees or cost of collection.

I have read the Insurance and Financial Policy and understand its contents.

_____ _____

Signature of Patient or Responsible Party Date

CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS
168 North Brent St. #508 Ventura California 93003
Phone (805) 643-2375 fax (805) 643-3511

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this California Cardiovascular and Thoracic Surgeon's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name: _____

Signed: _____ Date: _____

Print Name (If other than patient)**: _____**

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient