NORTHWEST VASCULAR CONSULTANTS, INC.
Vascular Surgery

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PATIENT REGISTRATION

Date:_____

PLEASE ANSWER ALL QUESTIONS

Name:_____ Date of Birth:_____ Sex: _____
(last) (first) (middle initial)

Address:_____

City:_____State:_____County_____Zip:_____

Home Phone:_____Cell Phone:_____

Email:_____

Social Security #:_____

Employer:_____Work Phone:_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Preferred Language:_____

Preferred Pharmacy? _____ Phone:_____

Referring Physician:_____

Primary Care Physician:_____

Responsible party, if other than patient:_____

Primary Insurance Company:_____

Subscriber:_____Relationship:_____
Date of Birth:_____
ID #:_____Group #:_____

Secondary Insurance:_____Relationship:_____
Date of Birth:_____
ID #:_____Group #:_____

Emergency contact:_____ Phone Number:_____
Relationship:_____

For Dialysis patients: Dialysis days_____ Shift:_____

Place:_____ Phone:_____

SIGNATURE ON FILE
FOR MEDICARE PATIENTS ONLY (INCLUDING HMO/MEDICARE INSURANCE COMPANIES)

I request that payment of authorized Medicare benefits be made on my behalf to Northwest Vascular Consultants, Inc. for any service furnished to me by the listed provider/supplier. I authorize any holder of my medical information to release it to the Health Care Financing Administration (HCFA) and its agents, to determine these benefits or benefits payable to related services.

Signature of Patient:_____Date:_____

PATIENT'S RESPONSIBILITY FOR PAYMENT

As a service to our patients we will submit charges for medical treatment to your insurance company. However, the patient is primarily responsible for paying any and all medical services provided by Northwest Vascular Consultants, Inc.

Our business office may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever the amount the insurance company does not pay.

If the patient participates in an HMO or PPO that requires a co-payment, the patient must pay the co-payment at the time of the appointment.

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical services provided by Northwest Vascular Consultants, Inc. If I do have insurance, I authorize release of all my medical information to my insurance company, and I authorize payment of all medical benefits by my insurance company to Northwest Vascular Consultants, Inc.

Signature of Patient or Guardian:_____Date:_____

REFERRAL RELEASE

I understand that a referral may be needed from my Primary Care Physician for this office visit or procedure. I also understand that it is my responsibility to make sure that the referral be issued. If a referral is not issued for this date of service by my Primary Care Physician, I will be solely responsible for the charges.

Date:_____ Signature of Patient:_____