The Stern Cardiovascular Foundation

PATIENT INFORMATION

Name:	**Date of Birth:** **Age:**
Address :	**Social Security #:** **Sex:**
City:	**Marital Status:**
State: **Zip:**	**Employer:**
Home Phone #:	**Employer Address:**
Work Phone #:	**Employer City:**
Cell Phone #:	**State:** **Zip:**
Stern Physician:	**Emergency Contact:**
Primary Care Physician:	**Phone #:**
Email Address:	**How did you hear about us?**
Patient's Race: (may include more than one race)	**Medical Record #: (office use only)**
Patient's Ethnicity:	**Patient Primary Language:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
ID #:	**ID # :**
Group Number:	**Group Number:**
Subscriber Name:	**Subscriber Name:**

Authorization for release of medical information: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services. **Assignment of Benefits:** I hereby authorize payment of benefits to be made directly to The Stern Cardiovascular Foundation, P.A. for services provided to me by said medical group. I understand that I am financially responsible to The Stern Cardiovascular Foundation, PA. for charges not covered by this assignment. I authorize a refund of overpaid insurance benefits in which my coverage is subject to coordination of benefits. In the event of a default, I agree to pay all costs of collection, including reasonable attorney's fees.

General Consent to Treatment and Test: (***Initial Here***) _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse, and or other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests, or other health care services ordered by my health care team. I understand that I may refuse specific treatments or procedures by informing my health care team.

COMMUNICATIONS REGARDING MY ACCOUNT:

I agree that the practice, Universal Collection System, or any other collection or servicing agency or agencies retained by the practice or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the practice may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the practice or is otherwise associated with my account. **Initial here: _____**

REFERRALS ARE REQUIRED AT TIME OF SERVICE.
In order to control our costs of billing, we request that office visit co pays be paid at the time the service is rendered. We would rather control our billing costs than be forced to raise our fees.

_____ _____
Signed (patient or parent if minor) **Date**

I acknowledge receipt of *The Stern Cardiovascular Foundation Privacy* Notice.

_____ _____
Signed (patient or parent if minor) **Date**