VITAL
HEART & VEIN

INSURANCE INFORMATION

Primary Insurance: ______________________________ Insurance Phone #: ______________________________
Policy ID #: ______________________________ Group #: ______________________________
Subscriber Name: ______________________________ Insured Date of Birth: ______________________________
Social Security #: ______________________________ Sex: ☐ Male ☐ Female

Secondary Insurance: ______________________________ Insurance Phone #: ______________________________
Policy ID #: ______________________________ Group #: ______________________________
Subscriber Name: ______________________________ Insured Date of Birth: ______________________________
Social Security #: ______________________________ Sex: ☐ Male ☐ Female

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

ASSIGNMENT OF BENEFITS:
The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claim for benefits, for services that will be bound by this signature as though the undersigned had personally signed the claim.

CONSENT TO CARE:
I authorize and direct Vital Heart & Vein to perform upon me injections, draw blood, and/or any other procedure or treatments the doctor may n his or her best judgment determine advisable for my well-being.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have received a copy of the Notice of Privacy Practices for Vital Heart & Vein. We reserve the right to modify the privacy practices outlined in the notice.

______________________________ ______________________ ______________
Signature of Patient/Parent/Guardian Relationship to Patient Date