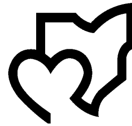

The Ohio Heart & Vascular Center

Patient Information and Consent

Patient Name ________________________________ Date of Birth __/__/___ M__F__

Address ____

City _____________ State ____ Zip ________ Home Phone # _____________________

Do you reside in a Nursing Home? Y__ N__ Name of Nursing Home________________

SSN _________________ Married ___ Single ___ Divorced ___ Widowed ___ Race ____

Employer _________________________________ Work Phone # ___________________

Address ______________________________ City ____________ State ___ Zip ________

Are You Retired? Y__ N__ Date of Retirement ___/___/___

Emergency Contact ________________ Relationship ___________ Phone # __________

Primary Care Physician _________________________ Phone # ____________________

Emergency Physician __________________________ Phone # _____________________

Primary Insurance ________________________________ Effective Date ____/____/____

Subscriber Name ________________________ Subscriber Date of Birth ____/____/____

Subscriber SSN _________________________ Relationship to Subscriber ___________

Subscriber Employer ____

Secondary Insurance _____________________________ Effective Date ____/____/____

Subscriber Name ________________________ Subscriber Date of Birth ____/____/____

Subscriber SSN _________________________ Relationship to Subscriber ___________

Subscriber Employer ____

Third Insurance ________________________________ Effective Date ____/____/____

Subscriber Name ________________________ Subscriber Date of Birth ____/____/____

Subscriber SSN _________________________ Relationship to Subscriber ___________

Subscriber Employer ____

Continued on Other Side of Page

We would like to make a copy of your insurance cards for our files. Please give to receptionist.

Consent for Treatment, Payment, and Operations.

I understand and agree that I and the Responsible Person signing below are responsible for payment of my bills. I authorize The Ohio Heart and Vascular Center, Inc. ("OHVC") to submit claims to my health insurance plans, whether private or governmental, for all services rendered by OHVC or by other health care providers involved in my care, including providers not employed by OHVC who are referred or consulted for my care by OHVC. I assign the benefits of such insurance to OHVC and authorize payment of claims directly to OHVC.

I consent to the use or disclosure by OHVC of my medical information and any other information about me in OHVC's possession for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of OHVC. This includes disclosure of information to other health care providers referred or consulted for my care, to health insurance plans, and to others engaged in health care operations such as training, credentialing, quality improvement, legal compliance, contracting, and administration.

I understand the information contained in this form or otherwise given by me to OHVC will be used in submitting claims for payment and I certify that such information is correct. I authorize a copy of this form to be used in place of the original, and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying OHVC of any precertifications required by my health plans. I understand that it is my responsibility to obtain referrals required by my health plans.

____
Patient Signature Date

____
Responsible Person Signature Date

____
Patient Name (Printed)

____
Responsible Person Name (Printed)

____
Patient DOB