HEART & VASCULAR SPECIALISTS, PC

Date _____ **Account Data Sheet**

Dear Patient: Kindly complete the data shown below for your contact information.
Note especially the authorizations below for family or care takers access.

Patient _____
Date of Birth _____
Address _____
City, State and Zip Code _____
Home Phone # _____
Cell Phone # _____ Text Y / N

Work Number # _____
Email address _____
Primary Insurance Information
Insured: _____
Insured DOB: _____
Plan Name: _____
Policy Number: _____
Group Number: _____

Primary Doctor _____
Lab Preference _____

Social Security _____ - _____ - _____
Martial Status (Circle one) S M D W
Employment Status Active Disabled Retired Unemployed
Circle one
Employer if applicable _____
Employer City/State _____
Secondary Insurance Information
Insured: _____
Insured DOB: _____
Plan Name: _____
Policy Number: _____
Group Number: _____

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1) I hereby authorize my insurance company's (named above) to pay benefits to Heart and Vascular Specialists, PC for services rendered.
2) By signing this consent form, you are granting written consent to Heart and Vascular Specialists, PC to provide medical treatment. You have the right to inquire to the cost and reason for any services ordered by your physician. Heart and Vascular Specialists, PC has the authority to disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations. Any other individual requests for your PHI other than "incidental", will require your signature releasing those records requested. {Such as life insurance applications, disability benefits, etc}. Give consent to access my medication list history without any restrictions.
3) I consent to receive phone calls, text messages, and email as a form of communications.
____ A. Phone Calls ____ B. Text Messages ____ C. Emails
4) I acknowledge that on request, I may view Heart and Vascular Specialists, PC's Privacy Notice.
5) I consent Heart and Vascular Specialist, PC's Medication History Authority.
6) We reserve the right to purge records after 10 years of inactivity.
7) You have the right, any time, to revoke the consent in writing. Direct revocation to Office Manager.
8) Please list any persons you would like to authorize to have access to your billing, appointment, or health information such as your spouse, caregiver, or family member:

NAME	RELATIONSHIP	PHONE
_____ Print Name	_____	_____
_____ Print Name	_____	_____
_____ Print Name	_____	_____
_____ Print Name	_____	_____

_____ Signature of Patient/Legal Guardian Date
Print Name _____

_____ Signature of Witness Date
Print Name _____