

# MORRISON VEIN INSTITUTE (Medicare Part B Insurance)

## PATIENT REGISTRATION

Please fill out completely

### Patient Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Preferred Name \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Address** \_\_\_\_\_ **Phone #** \_\_\_\_\_

Self Referred  Doctor Referral (Name & Phone of Referring Physician) \_\_\_\_\_

### Financial Guarantor Information (Policy holder or person other than patient guaranteeing payment)

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Sex \_\_\_\_\_ **DOB** \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

### Emergency Contact (Close friend or relative that we can contact in an emergency)

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### Primary Insurance Information

Insurance \_\_\_\_\_ Member/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

### Secondary Insurance Information

Insurance \_\_\_\_\_ Member/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Self pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided. In addition, Morrison Vein Institute is not contracted with any HMO; i.e., Secure Horizons, Pacificare, etc.

I request that payment of authorized insurance and Medicare benefits be made payable to Morrison Vein Institute on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Morrison Vein Institute to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

SIGNATURE OF PATIENT, INSURED, OR GUARANTOR

DATE \_\_\_\_\_