

UPDATE

PATIENT INFORMATION

JHC# _____

NAME OF REFERRING DOCTOR _____

DATE _____

PATIENT	SS NUMBER	MARITAL STATUS					SEX		BIRTHDATE
		S	M	W	D	SEP	M	F	
PHYSICAL ADDRESS	CITY AND STATE					ZIP CODE		HOME PH. #	
MAILING ADDRESS	CITY AND STATE					ZIP CODE		CELL #	
PATIENT OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)					HOW LONG EMPLOYED?		BUS. PH. #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE			
SPOUSE OR PARENT'S NAME	SS NUMBER							BIRTH DATE	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)					HOW LONG EMPLOYED?		BUS. PH. #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE			
NEXT OF KIN	STREET ADDRESS, CITY, STATE					ZIP CODE		HOME PH. #	
NAME OF INSURANCE COMPANY	STREET ADDRESS		CITY		STATE		ZIP CODE		
SUBSCRIBER'S NAME	SUBSCRIBER'S #		GROUP #				PHONE #		
NAME OF INSURANCE COMPANY	STREET ADDRESS		CITY		STATE		ZIP CODE		
SUBSCRIBER'S NAME	SUBSCRIBER'S #		GROUP #				PHONE #		
MEDICARE #	EFFECTIVE DATE		MEDICAID #				EFFECTIVE DATE		
IF THIS VISIT IS COVERED BY WORKMAN'S COMPENSATION - LIST CARRIER								DATE OF INJURY	

PLEASE READ AND SIGN OTHER SIDE

I understand that all professional services rendered are charged to me. Necessary forms will be completed to help expedite insurance carrier payments. However, I assume responsibility for all fees, regardless of insurance coverage.

MEDICARE PATIENTS - I understand Jackson Heart Clinic, P.A. accepts Medicare assignment on Medicare patients. However, I am responsible for the 20% co-pay as well as "non-covered" expenses and that I assume responsibility for any balances not covered by Medicare.

Jackson Heart Clinic, P.A. will file only one supplement insurance. If I have more than one Medicare supplement I will be charged \$4 for each additional insurance claim form processed on my behalf. This fee must be paid in advance.

I understand that I will pay \$15 in advance for each disability claim I wish Jackson Heart Clinic, P.A. to complete.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____

I request that payment of authorized Medicare and Blue Cross Key Physician benefits be made to me or on my behalf to Jackson Heart Clinic, P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature request that payment be made and authorizes the release of medical information to pay the claim. If item 9 on the HCFA - 1500 claim is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare and Blue Cross Key Physician assigned cases, the physician agrees to accept the charge determination of the Medicare and Blue Cross Key Physician as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare and Blue Cross Key Physician Plan.

Signature _____ Date: _____

I WILL BE PAYING FOR TODAY'S SERVICES WITH: _____ CASH, _____ CHECK, OR _____ CREDIT CARD.