ALEX HARRISON, M.D. INC **CENTRAL COAST COMPREHENSIVE CARDIOVASCULAR IMAGING**

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PATIENT NAME____TODAY'S DATE__________

STREET ADDRESS____

CITY____STATE______ZIP______________

HOME PHONE___________________________WORK PHONE___________________________

SOCIAL SECURITY#__________________________DATE OF BIRTH______________________ _ MALE _ FEMALE

EMPLOYER___________________________________OCCUPATION_______________________

EMPLOYER ADDRESS____

PRIMARY CARE PHYSICIAN____________________________________PHONE______________

MARITAL STATUS: _ MARRIED _ DIVORCED _ WIDOWED _ SINGLE _ SEPARATED

EMPLOYMENT STATUS: _FULL _RETIRED _SELF EMPLOYED _PART _NONE _ACTIVE MILITARY

PERSON TO CONTACT FOR EMERGENCIES_____________________________PHONE______________
(OTHER THAN AT YOUR HOME PHONE)

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PRIMARY INSURANCE____

CLAIMS ADDRESS____

INSURED'S NAME____

RELATIONSHIP TO PATIENT: _ SELF _ CHILD _ SPOUSE _ OTHER

INSURED'S DATE OF BIRTH______________________ _ MALE _ FEMALE

ID#____GROUP#________________

SECONDARY INSURANCE____

CLAIMS ADDRESS____

INSURED'S NAME____

RELATIONSHIP TO PATIENT: _ SELF _ CHILD _ SPOUSE _ OTHER

INSURED'S DATE OF BIRTH______________________ _ MALE _ FEMALE

ID#____GROUP#________________

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RESPONSIBLE PARTY____ _ SPOUSE _ GUARDIAN _ PARENT _ OTHER:__________

ADDRESS____

HOME PHONE____________________WORK PHONE____________________SOCIAL SECURITY______________

EMPLOYER____

EMPLOYER ADDRESS____

PLEASE COMPLETE BOTH PAGES OF THIS FORM

PATIENT MEDICARE / INSURANCE AUTHORIZATION

Patient's Name____Date of Birth_______________

I authorize payment of medical benefits to the physician or supplier listed below for services furnished to me or on my behalf. I also authorize the release of any medical or other information necessary to process claims for service rendered to me or on my behalf.

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I understand my signature authorizes release of any medical information necessary to process claims related to my healthcare and services provided to me or on my behalf, **and** authorizes that payment of such services be made to the provider(s) listed above. If "other health insurance" is indicated in Item 9 of the CMS1500 Form, electronically submitted format, or other approved claim form, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned and physician-carrier contracted cases, the physician agrees to accept the charge determination of the Medicare or other carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copayment and non-covered service amounts. Deductible, coinsurance and copayment amounts are based upon the Medicare / Insurance carrier's determination. I understand copays are due in full at the time services are rendered. I understand it is my responsibility to see that all services are paid in full by my insurance carrier and/or myself in a timely matter. I agree to pay court costs and collection fees and/or reasonable attorney fees if any delinquent account is placed with a collection agency and/or attorney for collection or suit. I acknowledge the information provided on this form is true and correct.

____ _______________
(Patient's Signature) (Date)

____ _______________
(Authorized Representative) (Date)

Thank you for taking the time to complete this information form as completely as possible. **Please notify our office if your insurance, address or phone number changes.** If you have any questions regarding our financial policy or insurance billing, please do not hesitate to ask our office manager. Physicians' Billing Services will be billing your primary and secondary insurance carriers. You may contact their office at (805) 614-9834.

Thank you again.