PACIFIC VASCULAR SPECIALISTS

PATIENT INFORMATION

DATE: _____

Patient Name: _____ DOB: _____

Mailing Address: _____

Phone: _____ Cell: _____

May we leave personal medical information on your voicemail or answering machine? YES NO

Email: _____

Preferred method of contact? □ Letter/Mail □ Phone □ Email

Race: _____ Ethnicity: _____ Language: _____

Occupation/ Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

May our office discuss your medical information with other family / friends? YES NO

If yes, please provide names and phone numbers below:

Name/ Relationship: _____ Phone: _____

Name/ Relationship: _____ Phone: _____

Name/ Relationship: _____ Phone: _____

PRIMARY INSURANCE COVERAGE:

Insurance Carrier: _____

ID# _____ Group# _____

Policy Holder: _____ DOB: _____

Relationship to Patient: □ SELF □ SPOUSE □ PARENT □ OTHER: _____

SECONDARY INSURANCE COVERAGE:

Insurance Carrier: _____

ID# _____ Group# _____

9155 SW Barnes Rd. Ste. 321 Portland, OR. 97225
PH: 503-292-0070
FX: 503-292-7731

Dr. John W. Wiest
Dr. R. Brad Cook
Dr. John N. Dussel
Erin Bolken PA-C
Kimberly Grady PA-C

Policy Holder: _____ DOB: _____

Relationship to Patient: □ SELF □ SPOUSE □ PARENT □ OTHER: _____

PATIENT'S RESPONSIBILITY FOR PAYMENT

As a service to our patients we will submit charges for medical treatment to your insurance company. However, the patient is primarily responsible for paying any and all medical services provided by Pacific Vascular Specialists.

Our business office may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance.

Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amount the insurance company does not pay. If the patient participates in an HMO or PPO that requires co-payment, the patient must pay at time of services. In the event that you do not pay your co-payment at the time of service you will be charged a $5.00 service fee in addition to your co-payment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to Pacific Vascular Specialists, PC and authorize them to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid for by my insurance.**

REFERRAL RELEASE

I understand that a referral may be needed from my Primary Care Physician for this office visit, procedure and for future appointments. If a referral is NOT issued for the dates of service by my Primary Care Physician, I will be solely responsible for the charges:

BY SIGNING BELOW, I agree to and understand the information above and the information I provided is accurate to the best of my knowledge.

BY: _____ DATE: _____
(PATIENT)

OR

BY: _____ DATE: _____
(PATIENT REPRESENTATIVE)

Representative's Relationship to Patient: _____

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