# *Heritage Valley Health System*

____ **Heritage Valley Medical Group** ____ **Heritage Valley Pediatrics** ____ **Tri State OB/GYN**

## PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # MARITAL STATUS

( ) S M W Sep Div

SOCIAL SECURITY # E-MAIL ADDRESS **RACE** (CIRCLE ONE) **ETHNICITY** (CIRCLE ONE) OCCUPATION (CIRCLE ONE)

American/AK Indian; Black/African American Not of Hispanic Origin

CELL# ALTERNATE# Asian/Pacific Islander; White Hispanic Origin FT PT RET Not Employed

Unknown/ Decline Unknown/ Decline

EMPLOYER OR NAME OF SCHOOL ADDRESS TELEPHONE # ARE YOU A STUDENT?

( ) Yes No Part time Full time

## SPOUSE, PARENT OR GUARDIAN INFORMATION *(If under 18, name of parent with whom you reside)*

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # RELATIONSHIP TO PATIENT

( ) Spouse Parent Other

SOCIAL SECURITY # EMPLOYER NAME AND ADDRESS EMPLOYER TELEPHONE #

( )

## INSURANCE INFORMATION ****PLEASE HAVE CARDS READY FOR STAFF TO COPY****

NAME OF **PRIMARY INSURANCE CO.**

INSURED'S NAME (**Subscriber of insurance**) SUBSCRIBER'S BIRTHDATE

**HOLDER'S RELATIONSHIP TO PATIENT: Circle one**
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child
Foster Child
Significant Other Life Partner Grandchild Organ donor

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

**AMOUNT OF CO-PAY** FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF **SECONDARY INSURANCE CO**

INSURED'S NAME (**Subscriber of insurance**) SUBSRIBER'S BIRTHDATE

**HOLDER'S RELATIONSHIP TO PATIENT: Circle one**
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child
Foster Child
Significant Other Life Partner Grandchild Organ donor

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?
**You are required to complete an additional form.**

o Automobile o Other _____
o Workmen's Comp o None

**Will patient be best served in a language other than spoken English? :** ° No ° Yes If yes, please specify_____

## EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP:

TELEPHONE # - HOME ( )
TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Heritage Valley Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____
PATIENT OR RESPONSIBLE PARTY

***TURN OVER TO NEXT PAGE***

**PATIENT NAME:** _____ **D.O.B.**_____

**ASSIGNMENT OF BENEFITS**

**MEDICARE PATIENTS:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

***I have read the above and fully understand my financial obligation.***

_____ _____ _____

Date Patient Signature HIC #

**MEDIGAP PATIENTS:**

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

***I have read the above and fully understand my financial obligation.***

_____ _____ _____

Date Patient Signature HIC #

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o **BLUE SHIELD PATIENTS**
We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

o **COMMERCIAL HEALTH INSURANCE PATIENTS**
As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

o **HMO AND PPO PATIENTS**
We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

o **SELF PAY PATIENTS**
Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

***I have read the item checked above and fully understand my financial obligation.***

_____ _____

Date Patient Signature