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HERITAGE VALLEY HEALTH SYSTEM

HVMG Primary Care – Ellwood City
Franklin Plaza, 273 Rt. 288, Ellwood City, PA 16117
Phone: 724-773-8388

PATIENT INFORMATION:

Patient Name: ____ Sex: M / F Date of Birth: ________________

SS# ______________________ Home Phone: ________________________ Cell Phone: ______________________

Address: ____

Employment (Circle One): FT / PT / Retired / Not Employed Occupation: _____________________

Name of Employer: ____ Phone: ___________________

Race (Circle): Am. Indian-Alaska Native/Asian/Black-African Am./Native Hawaiian/Pacific Islander/White/Declined

Other: _____________ Primary Language: ______________________

Ethnicity (Circle): Hispanic/Latino/Not Hispanic-Latino/Decline/Unknown

Do you have a living will / advanced directive? Y N (Forms are available upon request)

Emergency Contact: Name: _______________________________________ Phone: ______________________________

Relationship to Patient: ____

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service/supplier for any services furnished to me by that physician/supplier. 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 for related services. // We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible. It is your responsibility to know your co-insurance coverage. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. We will file your co-insurance one time only.

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

COMMERCIAL (through your employer or self-purchased) / MEDICAID or CHIP Health Insurance Coverage / Self-Pay (no insurance coverage)

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 responsible for any applicable co-payments and deductibles. Payment for office visits is due in full at the time of service.

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

HMO & PPO PATIENTS: We participate in numerous HMO & 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.

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 above and fully understand my financial obligation.

_______________________________________ ________________________
Patient Signature Date

All Insurance Information will be reviewed with the office staff and the patient's insurance card must be presented to the staff at each visit. All co-pays are due at the time of the visit.

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 any/all HVHS office, physician and/or subsidiary including but not limited to HVMG, SVMG, TSMG, TSPed, TSOb/Gyn, etc. 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 responsibility for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature: ____ Date: ___________________