

Heritage Valley Multispecialty Group – Cherrington Medical Associates

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)
CELL#	ALTERNATE#	American/AK Indian; Black/African American		Not of Hispanic Origin	FT PT RET Not Employed
		Asian/Pacific Islander; White/		Hispanic Origin	
		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 #
				()	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.		HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent 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 Other :Specify: _____
INSURED'S NAME (Subscriber of insurance)	SUBSCRIBER'S BIRTHDATE	
ID # OR AGREEMENT #	GROUP #	
EFFECTIVE DATE		

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

NAME OF SECONDARY INSURANCE CO		HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent 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 Other :Specify: _____
INSURED'S NAME (Subscriber of insurance)	SUBSCRIBER'S BIRTHDATE	
ID # OR AGREEMENT #	GROUP #	
EFFECTIVE DATE		

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

- Automobile Workmen's Comp None Other _____

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 Pediatric Group/ Heritage Valley OB/GYN/ Heritage Valley Multispecialty Group/ 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

I acknowledge I have received a copy of Heritage Valley Health System's Notice of Privacy Practices for Protected Health Information.

Signed: _____ DATE: _____

Please tell us how you heard about our practice: Friend/family Newspaper Internet Website Other _____

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 #

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