Downriver Heart & Vascular Specialists

15150 Fort Street
Southgate, MI 48195
734-282-4800

Name:_____
Last **First** **Middle Initial**

Birthdate:_____ **( ) Male ( ) Female ( ) Other**_____ **Soc Sec#:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone: (___)_____ **Cell Phone:(___)**_____

Email:_____**@**_____

Emergency Contact:_____ **(___)**_____
Name/Relationship **Phone Number**

Primary Care Physician:_____

Referring Physician:_____

Pharmacy Name:_____

How do you wish to be contacted regarding your Health Information?

Phone **Mail** **Email** **Other:**_____

Who do you permit us to speak with regarding your Personal Health Information?

Name:_____ **Relationship:** _____ **Ph#**_____
Name:_____ **Relationship:** _____ **Ph#**_____

(PLEASE TURN OVER TO COMPLETE and SIGN BACK)

Primary Insurance Information:

Plan Name:_____

Name of Insured:_____ **Insured Birth Date:**_____

Insured Soc Sec #:_____

Relationship to patient:_____ **Insured ID #:**_____

Secondary Insurance Information:

Plan Name:_____

Name of Insured:_____ **Insured Birth Date:**_____

Insured Soc Sec #:_____

Relationship to patient:_____ **Insured ID #:**_____

YOU WILL BE ASKED FOR YOUR INSURANCE CARDS AND PHOTO ID AT EVERY APPOINTMENT TO ENSURE RECORD ACCURACY AND PREVENT MEDICAL FRAUD.

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or to myself. I understand that I am financially responsible for all charges not covered by my insurance.

By signing the following, you acknowledge that the above information provided is correct to the best of my knowledge and that you were provided a copy of our Financial Policy as well as a copy of our Notice of Privacy Practices.

X_____ _____

Patient or Authorized Representative Signature **Date**

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MRN: _____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient /Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

Downriver Heart & Vascular Specialists

K. Gowda, M.D., F.A.C.C.
M. Hashem, M.D., F.A.C.C., F.S.C.A.I
Q. Shafiq, M.D., MMSc, F.A.C.C.
M. Husain, M.D.

15150 Fort St.
Southgate, MI 48195
Phone: 734-282-4800
Fax: 734-282-9302

Patient:

DOB:

Testing Date:

Here at Downriver Heart and Vascular Specialists, we understand that you may need to reschedule appointments from time to time. When we make your appointment for any form of testing, we are reserving a specific time spot for you that is taking a time slot away from another patient. If you cannot make your appointment, we need a 24 hour notice prior to your appointment time; otherwise, there will be a cash price charge of $50 for this occurrence. Your insurance will not cover this cost and $50 must be paid prior to rescheduling the test. Unfortunately, non-compliance to this agreement will void any appointment that has been made for any form of testing.

Thank you for your cooperation,

DHVS Management

Patient Signature

X_____ Date:_____