SKYLINE CARDIOVASCULAR INSTITUTE

111 STONEBRIDGE BLVD
JACKSON, TN 38305
(731) 410-6777 (731) 410-6778 (F)

Patient full name: _____ Gender: _____

SS#: _____ Birth date: _____ Marital status: _____

Mailing address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email: _____

Employer name, address and phone: _____

_____

Emergency contact: _____ Phone: _____

Primary care physician: _____ PCP Phone: _____

Physician requesting consultation (if applicable): _____

Individual(s) authorized to discuss your conditions or test results:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance name: _____

Insured name: _____

Birth date of insured: _____

ID#: _____

Group/policy#: _____

SS# of insured: _____

SECONDARY INSURANCE INFORMATION

Insurance name: _____

Insured name: _____

Birth date of insured: _____

ID#: _____

Group/policy#: _____

SS# of insured: _____

Please have all insurance and drug cards ready to present to the receptionist.

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RESPONSIBLE PARTY INFORMATION

(Complete this section only if you would like primary contact from our clinic to be someone other than yourself.)

Contact name (First, MI and Last): _____

SS#: _____ Birth date: _____ Gender: _____

Mailing address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email: _____

Employer name and phone: _____

_____

TREATMENT AND BILLING DISCLAIMER

I agree to and authorize medical treatment as deemed necessary by the Skyline Cardiovascular Institute, PLC. I hereby authorize the Skyline Cardiovascular Institute, PLC to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Skyline Cardiovascular Institute, PLC all insurance benefits payable to me by my insurance company, not to exceed the charges billed. I understand that I am financially responsible for any amount that is not covered by my insurance and this authorization. The Skyline Cardiovascular Institute, PLC can not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his or her account is turned over to an attorney, the undersigned shall be responsible for all costs of collection, including out of pocket expenses, court costs and attorney fees.
I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Skyline Cardiovascular Institute, PLC for any services furnished me by the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services.

Signed by patient or responsible party: _____ Date: _____

PRIVACY NOTICE

I acknowledge that I have received the Notice of Privacy Practices provided by the Skyline Cardiovascular Institute, PLC.

Signed by patient or responsible party: _____ Date: _____