Central Kentucky Cardiology

PATIENT/INSURANCE INFORMATION

Please make sure that all the information below is correct. Complete any missing information so that all of your insurance claims will be billed correctly.

Name:	**Date of Birth:**
Address 1:	**Social Security #:**
Address 2:	**Sex (circle one): Male Female**
City:	**Language:**
State: Zip:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone #:**
Cell Phone#:	**Emergency Relationship:**
Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group #:	**Group #:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name/Relationship:	**Subscriber Name/relationship:**

Release of information, benefit assignment, payment authorization, full disclosure statement, payment agreement and permission to treat.

I hereby authorize Central Kentucky Cardiology to release any information necessary to process my insurance claims, acquired in the course of my examination or treatment. I authorize Central Kentucky Cardiology to use a photocopy of my insurance signature to process my insurance claims. I request payment of benefits to myself or Central Kentucky Cardiology when assignment is accepted. Regardless of my insurance health benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. Permission for treatment is granted for such medically and surgical treatment as deemed necessary.

Signature:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices.

I, _____, acknowledge that I have received a copy of Central Kentucky Cardiology's Notice of Privacy Practices. My signature below indicates that I have received the notice and that I have been provided an opportunity to ask questions about the company's privacy practices as they pertain to my protected health information

Signature:_____ Date:_____