

VITAL

HEART & VEIN

INSURANCE INFORMATION

Primary Insurance: _____ Insurance Phone #: _____
Policy ID #: _____ Group #: _____
Subscriber Name: _____ Insured Date of Birth: _____
Social Security #: _____ Sex: Male Female

Secondary Insurance: _____ Insurance Phone #: _____
Policy ID #: _____ Group #: _____
Subscriber Name: _____ Insured Date of Birth: _____
Social Security #: _____ Sex: Male Female

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

ASSIGNMENT OF BENEFITS:

The undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claim for benefits, for services that will be bound by this signature as though the undersigned had personally signed the claim.

CONSENT TO CARE:

I authorize and direct Vital Heart & Vein to perform upon me injections, draw blood, and/or any other procedure or treatments the doctor may in his or her best judgment determine advisable for my well-being.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Vital Heart & Vein. We reserve the right to modify the privacy practices outlined in the notice.

Signature of Patient/Parent/Guardian

Relationship to Patient

Date

Vital Heart & Vein

Memorial Hermann Medical Plaza

Pearland Medical Plaza 2

18450 Hwy. 59
Humble, TX 77338

6400 Fannin, Suite 2210-B
Houston, TX 77030

10907 Memorial Hermann Dr., Suite 370
Pearland, TX 77584

