ALL FIELDS ARE MANDATORY

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_SOCIAL SECURITY #\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE#:\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

CITY/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE#:\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

YOUR PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW DID YOU HEAR ABOUT US? CIRCLE ONE:

PHYSICIAN SELF NEWSPAPER BILLBOARDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BY SIGNING HEREWITH, I GIVE CONSENT TO GENESIS HEART AND VASCULAR ASSOCIATES TO THE FOLLOWING:

* Use my protected health information to carry out treatment, payment and healthcare information.
* Bill my insurance company for services rendered to me by them.
* Send my health information by regular mail, phone or email including but not limited to statements, appointment reminders and test results.
* I agree to give my most updated insurance information at each visit
* I understand that all office visit copays are due at the time of check in
* I understand that I am responsible for all deductibles, coinsurance on the day of my office visit or procedure day and that all patient balances and that these are due within 30 days of receiving statements
* I understand that I have to call at least 24 hours before the scheduled appointment to cancel or reschedule it.
* I hereby agree to pay any and all collection costs including but not limited to collection agency fees court costs.
* Sharing my most updated health insurance is my responsibility and I do not hold anyone else responsible for checking insurance eligibility and benefits for me
* I understand that I will be responsible for coordination of benefits prior to any services rendered.

HEALING WITH COMPASSION, COURTESY AND RESPECT

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