PACIFIC VASCULAR

11714 N Creek Pkwy N, #100, Bothell, WA 98011
Patient Accounting: 425.486.8328
Toll Free: 800.741.3317
Tax ID #: 91-1347951 • NPI #: 1750436945

PATIENT INFORMATION

Name: _____ Today's Date: _____
(Last Name, First Name, Middle Initial)

Date of Birth: ____ / ____ / _____ Sex: ☐M ☐F ☐Undefined/Unknown Last 4 Digits SSN (optional):_____
MM / DD / YYYY

Home Address:_____

City:_____ State:_____ Zip:_____ Email: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referring Physician/Healthcare Provider Name: _____

Primary Care Provider (PCP) Name: _____

Send additional copy of report to: (optional) _____

INSURANCE: Please submit your insurance cards & ID, so that we may make a copy

Primary Insurance Name: _____ ID Number:_____

Group#/Group Name/Employer Name:_____

Name of Subscriber if other than patient: _____ Relationship: ☐Spouse ☐Child ☐Other_____

Subscriber's DOB: _____

Secondary Insurance Name: _____ ID Number:_____

Group#/Group Name/Employer Name:_____

Name of Subscriber if other than patient: _____ Relationship: ☐Spouse ☐Child ☐Other_____

Subscriber's DOB: _____

Name of Skilled Nursing Facility (if applicable): _____

CONSENT FOR TREATMENT & RELEASE OF INSURANCE BENEFITS

1) I hereby authorize Pacific Vascular, Inc. to render the diagnostic test ordered by my healthcare provider. The test was explained to my satisfaction, including the purpose of the test and associated risks. I further authorize that my insurance benefits be paid directly to Pacific Vascular.
2) I am financially responsible for any balance due with payment due within 30 days of billing. I accept full and complete financial responsibility for all medical services rendered to the registered patient and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan.
3) I authorize Pacific Vascular, Inc. to send a copy of my test results to my PCP for the continuation and management of my health care.

★_____ _____
Signature Date

VascuPro Order#:_____ Rev 03/04/2020