



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 as well as upload the report into my electronic health record (if applicable) for the continuation and management of my health care.

★ _____
 Signature

 Date