Elite Cardiac & Vascular Care

# INSURANCE INFORMATION FORM

## PRIMARY INSURANCE INFORMATION

Name of Insured: Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

SS#: _____ Driver's License #: _____ Relationship: _____

Insurance Company: _____

Policy #: _____ Group #: _____ Member ID#: _____

## SECONDARY INSURANCE INFORMATION

Name of Insured: Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

SS#: _____ Driver's License #: _____ Relationship: _____

Insurance Company: _____

Policy #: _____ Group #: _____ Member ID#: _____

## AUTHORIZATION & ASSIGNMENT

• AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND ASSIGNMENT OF BENEFITS.
I hereby authorize SEPIDEH KAZEMI MD to provide medical care and treatment and to release my medical information to my insurance company(s) as necesssary for the payment of benefits. I also authorize my insurance company(s) to pay benefits directly to SEPIDEH KAZEMI MD. These authorizations remain valid and effective from the date of signing until revoked in writing.

• FINANCIAL REPONSIBILITY. I understand that I am financially respondsible for the cost of all medical services. SEPIDEH KAZEMI MD will bill my insurance company strictly as a courtesy to me but any portion of my medical bill that does not get paid by insurance including but not limited to co-payments, deductibles, and non-covered amounts will be my responsibility. I agree to pay collection costs and reasonable attorney fees incurred in collecting outstanding balances. I understand that invoices sent by SEPIDEH KAZEMI MD are due upon receipt and that failure to keep my account current may result in my being denied additional services.

I acknowledge that I have read and understand my responsibilities and SEPIDEH KAZEMI MD's policies.

Patient Signature: _____ Date: _____

Patient Name (Print): _____