River Region Cardiology

185 Mitylene Park Lane Montgomery, AL 36117
334-387-0948 Office 334-387-0955 Fax

REFERRED BY: ______________________ **FAMILY PHYSICIAN:** ______________________

PATIENT'S LAST NAME ______________________ **FIRST** ______________________ **M.I.** ______

STREET ADDRESS ______________________ **APT. #** ______________________

CITY ______________________ **STATE** ____________ **ZIP** ____________

HOME PHONE ______________ **BUSINESS PHONE** ______________ **CELL/OTHER** ______________

SEX ________ **DATE OF BIRTH** ____________ **SOCIAL SECURITY NUMBER** ________ - ________- ____________

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

EMPLOYER'S NAME ____

EMERGENCY CONTACT (NAME & ADDRESS) ____

RELATIONSHIP TO PATIENT ______________________ **PHONE #** ______________________

FINANCIAL RESPONSIBILITY: ☐ **SAME** ☐ **SPOUSE** ☐ **OTHER**

LAST NAME ______________________ **FIRST** ______________________ **MIDDLE** ____________

ADDRESS ______________________ **CITY** ____________ **STATE** ______ **ZIP** ________

SOCIAL SECURITY NUMBER ________ - ______ - ________ **RELATION TO PATIENT** ____________ **DOB** ____________

HOME PHONE ______________________ **BUSINESS PHONE** ______________ **CELL PHONE #** ______________

EMPLOYER ______________________ **ADDRESS** ______________________ **CITY** __________ **ST** ______

NAME OF INSURANCE COMPANY ____

POLICY # ______________________ **GROUP #** ______________________ **EFFECTIVE DATE** ____________

MEDICARE # ______________________ **MEDICAID #** ______________________ **PATIENT 1ST** ____________

SECONDARY INSURANCE ____

POLICY # ______________________ **GROUP #** ______________________ **EFFECTIVE DATE** ____________

PAYMENT AGREEMENT ASSIGNMENT OF BENEFITS, RELEASE OF RECORDS AND AUTHORIZATION OF TREATMENT

I, the undersigned, promise to pay in full, to River Region Cardiology, PC for any and all charges in consideration of work done and materials furnished immediately upon such charges being incurred. Upon default, I agree to pay any rebilling charges, interest charges, reasonable legal fees, and all cost associated with the collection of this note.

I hereby authorize assignment of benefits to River Region Cardiology, PC for any medical services rendered by them. I also authorize the release of my medical records and any documentation necessary to obtain reimbursement for services rendered.

In the event that I am referred to another provider, I authorize River Region Cardiology, PC to forward my medical record as it relates to such referral to that provider. Additionally, upon my verbal request for a copy of my record and prepayment for such copies, this shall serve as sufficient authorization. A copy shall be valid as the original.

Signature of responsible party ______________________________________ **Date** ______________

M. Luqman Ahmed, MD   Pervaiz Malik, MD   Narinder Bhalla, MD