Northwest Vascular Consultants, Inc.
General and Vascular Surgery

_____ Gregory L. Geary, M.D., F.A.C.S.
_____ Philip T. Alexander, M.D.
_____ Jeffry D. Cardneau, M.D.

9155 SW Barnes Road, #318
Portland, OR 97225
(503) 292-9565

Patient Registration

Please complete and bring this form with you to your first appointment.

PLEASE ANSWER ALL QUESTIONS Today's Date: _____

Name: _____ Date of Birth _____ Age: _____
(last) (first) (middle initial)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security #:_____ Sex: ❑ Male ❑ Female

Employer: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name: _____

Spouse's Employer: _____ Work Phone: _____

Referred By: _____

Primary Care Physician: _____

Responsible party, if other than patient: _____

Primary Insurance Company: _____

Address: _____

Subscriber: _____ Relationship: _____

Date of Birth:_____

ID #: _____ Group #:_____

Secondary Insurance: _____

ID #: _____ Group #:_____

Relative or Close Friend: _____ Phone #:_____

Special Information: _____

SIGNATURE ON FILE
FOR MEDICARE PATIENTS ONLY (INCLUDING HMO/MEDICARE INSURANCE COMPANIES)

I request that payment of authorized Medicare benefits be made on my behalf to Northwest Vascular Consultants, Inc. for any service furnished to me by the listed provider/supplier. I authorize any holder of my medical information to release it to the Health Care Financing Administration (HCFA) and its agents, to determine these benefits or benefits payable to related services.

Signature of Patient: _____ Date: _____

PATIENT'S RESPONSIBILITY FOR PAYMENT

As a service to our patients we will submit charges for medical treatment to your insurance company. However, the patient is primarily responsible for paying any and all medical services provided by Northwest Vascular Consultants, Inc.

Our business office may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever the amount the insurance company does not pay.

If the patient participates in an HMO or PPO that requires a co-payment, the patient must pay the co-payment at the time of the appointment.

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical services provided by Northwest Vascular Consultants, Inc. If I do have insurance, I authorize release of all my medical information to my insurance company, and I authorize payment of all medical benefits by my insurance company to Northwest Vascular Consultants, Inc.

Signature of Patient or Guardian: _____ Date _____

REFERRAL RELEASE

I understand that a referral may be needed from my Primary Care Physician for this office visit or procedure. I also understand that it is my responsibility to make sure that the referral be issued. If a referral is not issued for this date of service by my Primary Care Physician, I will be solely responsible for the charges.

Date: _____ Signature of Patient: _____

Witness: _____

Date: _____ Signature of Patient: _____

Witness: _____

Date: _____ Signature of Patient: _____

Witness: _____

Date: _____ Signature of Patient: _____

Witness: _____