Virginia Y. Gonzalez, M.D.
Cardiovascular Diagnostic Center A.P.M.C.

Today's Date: _______________ **Primary Physician**: ____________________

Patient Information		
Patient Name- First, MI, Last	Social Security Number	Date of Birth
Marital Status S M W D Sex: Male Female	Mailing Address	City, State, Zip Code
Street Address (If different from above)	City, State, Zip Code	Home Phone #
Cell Phone #	E-mail Address	Employer-If Retired, Date retired
Employer's Address	Business Telephone #	Alternate #
Do you have a living will? □ Yes □ No	Pharmacy: ____________________	Location: ____________________
Please provide emergency contact information of a relative or friend not living with you.		
Emergency Contact Name	Relationship	Home Phone #
Street Address	City, State, Zip Code	Business Phone #
Policyholder Information (Please complete if the patient is not the policyholder) Same: [ ]		
Patient Name- First, MI, Last	Social Security # & Date of Birth	Relationship to Patient
Street Address	City, State, Zip Code	Home Phone #
Policyholder's Employer	Employer's Address	Business Phone #

Financial Responsibility

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is ultimately responsible for all fees charged for services rendered regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. If hospitalization is indicated, the patient is responsible for furnishing insurance claims to the office prior to hospitalization.

Pre-certification or Pre-authorization for Care

Many insurance policies and managed care plans require pre-certification from the carrier or advance authorizations from the patient's Primary Care Physician. When such pre-certification or pre-authorization is not obtained when non-emergency care is sought, the insurance policy or managed care plan may provide no or dramatically reduced benefits. Our office staff will assist you to the extent possible to secure such pre-certification or pre-authorization. Ultimately, it is the patient's responsibility to secure such pre-certification or pre-authorization under the terms and conditions of their insurance policy or managed care plan.

Truth In Lending Agreement & Assignment of Benefits

This date, I have contracted with *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* for the furnishing of medical or surgical procedures for illness or injury. I will be responsible for payment of the total bill incurred as a result of treatment received. Although I may choose to use insurance coverage to pay all or a portion of the bill incurred, I understand that the filing of insurance claims does not constitute payment of any portion of the bill and I understand that I am responsible for all charges billed to me for treatment. I accept full responsibility for payment of the total balance of my account. When the account becomes 90 days old, or after all insurance has been paid, a monthly finance charge of 1% will be applied to the remaining balance. I have this date assigned to *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* the benefits due to me under my existing policy or policies of insurance. I understand insofar as they are necessary to cover such expenses that the above assignment of insurance is accepted by *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* as a convenience to me and *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* is hereby given my consent to file claims on said policy or policies and to do such other actions as it deems necessary in connection therewith so as to obtain prompt payment under such policies. I authorize my insurance company to pay *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* direct, without payment to me.

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Patient or Responsible Party

Consent to Release of Medical and Insurance Information

I hereby authorize the physicians, employees and agents of *Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,* to examine any and all of my insurance and/or medical records; to obtain at their expense, photo static copies of such records as they may desire; to discuss my medical history, examination and treatment with physicians, nurses and other healthcare providers who have treated or examined me; and to release or discuss information relating to my care in order to expedite the processing of claims for reimbursement from insurers, managed care entities or other agencies responsible for claims processing. I further agree that this authorization shall be valid and effective unless and until it is revoked by me in writing. A photocopy of this authorization my serve as an original.

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Date	Witness	Patient's Signature