



Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthday: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: S M D Widowed Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Responsible Party (if not self): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Practice Physician: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Policy: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Insured Name (if other than patient): \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Policy: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Insured Name (if other than patient): \_\_\_\_\_

I HEREBY AUTHORIZE CARDIAC SURGERY ASSOCIATES AND ITS PHYSICIANS TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO ANY INSURANCE COMPANY, GROUP OR OTHER ORGANIZATION WHICH IS OR MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE PHYSICIANS CHARGES FOR THE SERVICES THEY PROVIDED.

I AUTHORIZE PAYMENT FOR THE SERVICES OTHERWISE PAYABLE TO ME BY ANY INSURANCE COMPANY, GROUP OR OTHER ORGANIZATION BE MADE ON MY BEHALF DIRECTLY TO THE CARDIAC SURGERY ASSOCIATES IN MEMPHIS, TENNESSEE.

I UNDERSTAND THAT WHILE INSURANCE PAYMENTS RECEIVED BY THE CARDIAC SURGERY ASSOCIATES WILL BE APPLIED TO MY ACCOUNT, I AM RESPONSIBLE FOR ANY UNPAID BALANCE AND GUARANTEE PAYMENT OF MY ACCOUNT, SHOULD IT BE NECESSARY TO TURN MY ACCOUNT OVER TO AN AGENCY FOR COLLECTION. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES, ATTORNEY'S FEES AND OTHER COLLECTION COSTS.

I AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE AS VALID AS THE ORIGINAL.

\_\_\_\_\_  
PATIENT'S SIGNATURE OR REPRESENTATIVE

\_\_\_\_\_  
DATE