

Cardiovascular Associates Of Rhode Island, Inc

Patient Registration

Please Print:

Patient Name _____ Male _____ Female _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Contact Phone _____

Social Security Number _____ Employer Name _____

Person to Notify in Emergency _____ Phone# _____ Relationship _____

Primary Care Physician's Name & Address:

Name _____ Address _____

Referring Physician's Name & Address:

Name _____ Address _____

Insurance Coverage

Name of Primary Insurance Company _____

Policy Number _____ Group Number _____

Subscriber _____ Date Of Birth _____

Relationship _____

Do you have a secondary insurance carrier? _____ Yes _____ No

If Yes, Name of Secondary Insurance Company _____

Policy Number _____ Group Number _____

Subscriber _____ Date Of Birth _____

Relationship _____

Please provide us with your insurance card(s) and picture ID so we can make a photocopy.
Thank you.

Over Please

Billing Procedures

1. This office participates in Blue Cross & Blue Shield of Rhode Island. Payment is requested on the day of service for any non-covered services including co-payments, office visits not covered because of deductibles, flu vaccines, etc.
2. For patients with Medicare and Plan 65. Assignment is accepted by this office. We will accept their payments in full. If you have Medicare with a private secondary insurance carrier, we will process the claim for you if the correct billing information and forms are provided. If you have Medicare without a secondary insurance, you will be billed for the 20% copay not covered by Medicare. You are responsible for your Medicare deductible not covered by your secondary insurance carrier.
3. We participate with Blue Chip, Neighborhood Health Plan, United Health Plan, Healthcare Value Management, and Aetna U. S. Healthcare. Most of these plans require a referral from your primary care physician. You are responsible for obtaining this referral from your primary care physician. If we have not received the referral by the time you come in for your appointment, you will be required to sign a "self-referral" form, which verifies that you will be responsible for payment of any charges denied by your insurance due to the referral not being in place.
4. If you have a private insurance carrier, please present your ID card so we can photocopy both sides and obtain the correct mailing address for claims, etc. You will be billed for any balance not paid by your insurance carrier or if your insurance carrier does not respond to our request for payment within 30 days.
5. Nutritional counseling is not a covered service by most insurance carriers.

Assignment of Benefits Authorization- Please Sign Below

I authorize my insurance company to pay benefits directly to Cardiovascular Associates of RI, Inc., which would otherwise be payable by me. I understand that I am financially responsible for charges not covered by my insurance carrier. I hereby authorize the release of my medical information, if required by the insurance carrier, *for the sole purpose of processing* my medical claim.

Patient Signature

Date Signed

Medicare Authorization

I request that payment of authorized Medicare insurance benefits be made on my behalf to Cardiovascular Associates of RI, for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agent any information needed to determine these benefits payable for related services.

Patient Signature

Date Signed