SOUTH ORANGE COUNTY CARDIOLOGY GROUP

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INFORMATION UPDATE

Name: _____

Address: _____
Street City State Zip

Telephone numbers: _____
Primary ☐ Home ☐ Cell ☐ Work Secondary ☐ Home ☐ Cell ☐ Work

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

I hereby authorize Dr. _____ to furnish the above insurance company (s) or a designated attorney all information requested by said insurance company(s)/attorney. I authorize the release of medication information necessary to process my claims. I authorize payment of medical benefits for services rendered by this group. In the event of no payment, I agree to bear the cost of collection and/or cost and reasonable legal fees should this be required.

I understand that I am financially responsible for charges when services are rendered to me and that payment is expected at the time services are rendered. I further understand that I am financially responsible despite the fact that Medicare or my private insurance carrier may not reimburse me for these services. In the event that Medicare denies payment, I may appeal the decision to Medicare.

Patient's Signature: _____ Date: _____