

PLEASE PRINT ONLY

TODAY'S DATE: _____

DATE STARTED DIALYSIS: _____

PATIENT'S NAME: _____

GIVE PATIENT'S NAME AS IT APPEARS ON INSURANCE CARD - ALL RECORDS WILL APPEAR UNDER THAT NAME ONLY

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

CAN APPOINTMENT REMINDER MESSAGES BE LEFT ON YOUR ANSWERING MACHINE? YES / NO

REFERRING PHYSICIAN: _____ **NAME OF DIALYSIS CENTER:** _____

ADDRESS: _____ **ADDRESS:** _____

PHONE: _____ **PHONE:** _____

SEX: MALE / FEMALE **MARTIAL STATUS:** MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED

PATIENT'S DATA:

SPOUSE'S DATA:

PATIENT'S SOCIAL SECURITY # _____ **SPOUSE'S NAME** _____

PATIENT'S DATE OF BIRTH: _____ **SPOUSE SOCIAL SECURITY #:** _____

PATIENT'S EMPLOYER: _____ **SPOUSE DATE OF BIRTH** _____

ADDRESS: _____ **SPOUSE EMPLOYER:** _____

PHONE: _____ **PHONE:** _____

EMERGENCY CONTACT:

NAME: _____ **PHONE #:** _____ **RELATIONSHIP TO YOU:** _____

PLEASE GIVE A NUMBER THAT WE MAY USE IF YOU ARE NOT AVAILIABLE - DO NOT GIVE YOUR HOME PHONE #

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY THAT ALL CHECKS FOR MY MEDICAL SERVICES PROVIDED BY KEVIN D. NOLAN, M.D. AND/OR WILLIAM F. OPPAT, M.D. AND/OR TAMER N. BOULES, M.D. AND/OR PRITHAM P. REDDY M.D. BE PAYABLE AND MAILED TO: COMPREHENSIVE VASCULAR CARE, P.C.

22250 PROVIDENCE DRIVE, SUITE 555
SOUTHFIELD, MI 48075

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE DR. NOLAN AND/OR DR. OPPAT AND/OR DR. BOULES AND/OR DR. REDDY TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSONER FOR ANY REASON ON MY BEHALF.

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ALL PROFESSIONAL SERVICES RENDERED. I HEREBY AUTHORIZE PAYMENT TO COMPRHENSIVE VASUCLAR CARE, P.C. FOR SURGICAL AND/OR MEDICAL BENEFITS. I HAVE READ AND COMPLETED ALL THE INFORMATION ON THIS FORM. I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY STATUS ON THE ABOVE INFORMATION.

PATIENT'S SIGNATURE: _____ **DATE:** _____

WITNESS' SIGNATURE: _____ **DATE:** _____

FOR PATIENT'S WITHOUT INSURANCE:

I WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT IN FULL OF MY MEDICAL CARE AT THE TIME SERVICE IS RENDERED.

PATIENT'S SIGNATURE: _____ **DATE:** _____

WITNESS' SIGNATURE: _____ **DATE:** _____