Premier Cardiology & Vascular Associates
Changing Lives Everyday

Amish M. Parikh, MD, FACC

Patient Information Update Form

Demographics:

Patient Name (please print clearly):______________________________

Address: _________________________________

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Home Phone: _________________ Cell/Mobile: __________________

Personal Email Address (please print clearly):_______________________________

Insurance

Has your insurance information changed since your last visit? ____Yes _____No

If yes, please see one of our staff members to update your insurance information.

Patient Financial Policy Agreement

By signing below, I acknowledge that I have previously read and have fully understood the Financial Policy for Premier Cardiology. I may request a copy of the full agreement again, should I want to review the terms. Please read the submission of claims acknowledgement below.

As a courtesy, we will bill your insurance company for the services provided to you. It is your responsibility, however, to know the benefits and conditions of your insurance plan. Some procedures require pre-certification or an authorization before the service is performed. If for some reason your insurance company fails to pay, we will expect you to pay the balance in full. By signing this form, you authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to you by **Premier Cardiology & Vascular Associates** now, in the past, or in the future, until such time as I revoke this authorization in writing. I authorize **Premier Cardiology & Vascular Associates** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **Premier Cardiology & Vascular Associates** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **Premier Cardiology & Vascular Associates**, now, in the past, or in the future. I also authorize **Premier Cardiology & Vascular Associates** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

670 N. Orlando Ave, Suite 1003, Maitland, FL 32751
Ph: 407 – 622 – 0793 Fax: 866 – 362 – 3655

Privacy Practices Acknowledgment

By signing below, I acknowledge that **Premier Cardiology & Vascular Associates** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient (HIPPA). ***A copy of this form is valid as an original***

Patient Portal Authorization

By signing below, I acknowledge that I have previously read and have fully understood the consent form. I may request the full consent form again, should I want to review the terms. I understand that this agreement will remain in effect for 12 months. At the end of that time, I will be asked to renew my confidential email and Patient Portal Login. It is my responsibility to notify Premier Cardiology & Vascular Associates if there is a change in my email account or I feel that my secure password has been breached. I have asked questions related to this consent agreement and believe that all of my questions have been answered with clarity.

Patient /Guardian Signature: ____ Date:_________