SALVATORE A. BARBARO III, MD, PA

Specializing in General & Interventional Cardiology,
Electrophysiology and Endovascular Diseases

Patient Name: _____ Date: _____

Address: _____APT: _____ City, State, Zip: _____

Pt DOB: _____ Age: _____ SS #_____ Sex: M / F

Home Phone: _____ Cell Phone: _____

EMAIL ADDRESS: _____ Marital Status: **M / S / D / W**

Occupation: _____ Employer: _____Retired: YES\NO

Work Phone: _____ Referring Dr\ PCP Name: _____

Race (Circle): Caucasian/ African American/ Hispanic/ Asian/ American Indian/ Other: _____

EMERGENCY CONTACT: _____ Relationship: _____

Primary Phone: _____ Alternate Phone #: _____

(1.) PRIMARY INSURANCE: _____ID#: _____GR #_____

Policyholder: _____ Relationship: _____

Policyholder's Social Security#: _____ Policyholder's DOB: _____

(2.) SECONDARY INSURANCE: _____ID#: _____GR #_____

Policyholder: _____ Relationship: _____

Policyholder's Social Security #: _____ Policyholder's DOB: _____

ASSIGNMENT AND RELEASE: I, the undersigned, assign directly to Salvatore A. Barbaro, III, MD, P.A. all medical benefits, if any, otherwise payable to me for services rendered on my behalf or on behalf of my dependents. I hereby authorize, Salvatore A. Barbaro, III, MD, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Signature of Insured / Guardian: _____Date: _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Salvatore A. Barbaro, III, MD, P.A. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, coinsurance and non-covered services**. Coinsurance and the Deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF BENEFICIARY: _____DATE: _____