General & Vascular Surgery of NW AL, Inc.
Jeffrey D. Manord, M.D.

Date: ___________

Patient Full Name: _______________________________

Date of Birth: ___________ Age: ____ Social Security No: ______________________

Sex: ___M ___F Race: ________________ Primary Language _________________

Ethnicity: ____Hispanic ____non-Hispanic ____No Comment

Email Address____

Marital Status: ___Single ___Married ___Widowed ___Divorced ___Separated

Mailing Address: ____

City:____ State: ____ Zip Code:__________

Home Phone No: _____________ Cell No: _____________ Other: _______________

Patient's Employer: ____

Employer's Phone No: ______________

Person Responsible for bill: ____

Responsible Party's Address: ____
____

Name of Primary Insurance: ____

Subscriber Name: _____________________________ Contract #: _____________

Subscriber Date of Birth: ________________ Subscriber SS #: _____________

Your relationship to subscriber: ____

Name of Secondary Insurance: ____

Subscriber Name: _____________________________Contract #: _____________

Subscriber Date of Birth: ________________ Subscriber SS #: _____________

Your relationship to subscriber: ____

Who is your Primary Care Doctor (family doctor): ______________________

Who referred you to our office? ____

Person to notify in case of a medical emergency: _____________________

Phone number: __________________ Relationship to patient: ______________

PAYMENT is due from the patient at the time services are rendered. The patient is responsible for payment and not the insurance company. We will file claims for any insurance coverage; however, co-payments, deductibles, and non-covered charges must be paid at the time services are rendered. If there are any questions regarding payment/insurance filing policies, please see one of the office staff at this time to make any necessary arrangements.

AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such are necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. The undersigned understands that accounts may be referred to an outside collection agency if the balance remains unpaid for sixty days unless alternate arrangements have been made and followed.

RELEASE OF MEDICAL RECORDS: I authorize General & Vascular Surgery of NW AL, Inc. to request or release any medical information from or to another physician or medical institution as necessary for my medical care and for insurance filing purposes.

SURGICAL BENEFITS: I authorize payment directly to General & Vascular Surgery of NW AL, Inc. for the surgical and/or medical benefits, if any, otherwise payable to me for the services rendered by General & Vascular Surgery of NW AL, Inc. I realize the insurance benefits may not pay the entire bill and I agree to pay the difference or the entire bill if necessary, excluding contractual allowances.

Signature of Responsible Party: ____

Date: _____________________