

**MEMPHIS HEART CLINIC  
INSURANCE/FINANCIAL INFORMATION**

**INSURANCE INFORMATION**

(please print)

**PATIENT NAME:** \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

**Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_ **DOB** \_\_\_\_\_

Does this insurance have a prescription plan? **Yes** **No** Does this insurance require a referral? **Yes** **No**

Co-pay \_\_\_\_\_ Is Pre-cert required for IN patient or OUT patient services? \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

**Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_ **DOB** \_\_\_\_\_

Does this insurance have a prescription plan? **Yes** **No** Does this insurance require a referral? **Yes** **No**

Co-pay \_\_\_\_\_ Is Pre-cert required for IN patient or OUT patient services? \_\_\_\_\_

**FINANCIAL POLICY**

We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card (s). You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company.

After we have received payment from your insurance company you will receive a statement showing the balance due from you. This amount is your responsibility and is due within 30 days of the statement date. A return-addressed envelope will be included for you to mail in your payment or you may make payments at any of our offices. We accept cash, checks, Visa, MasterCard, Discover and American Express.

If you have any questions regarding the balance on your account, please call our business office at 901/753-5440.

I hereby provide consent for Memphis Heart Clinic to release my protected health information for payment. Additionally, I request that payment of authorized insurance benefits (including Medicare benefits, if applicable) be made on my behalf to Memphis Heart Clinic for any services furnished to me by Memphis Heart Clinic. I authorize Memphis Heart Clinic to release medical information about me to my Insurance Carrier and/or Center for Medicare and Medicaid Services, if applicable and its agents to the extent necessary or desirable to determine these benefits or benefits payable for related services.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Patient/Parent/Guardian Signature)