ELECTROPHYSIOLOGY ASSOCIATES, PA
PATIENT INFORMATION RECORD

Initial Date of Service ____________

PATIENT INFORMATION			
Patient Name:			Gender: M F
Birthdate:	Social Security #:		Marital Status: S W D M
Mailing Address:			Apt#:
City:		State:	Zip Code:
Home Phone:		Mother's Maiden Name:	
Cell Phone:		Reason for this Visit:	

VERY IMPORTANT: US Government Healthcare laws require the following information:

Referring MD:

Patient's Race (Please CIRCLE your selection):	Asian	Black	Hispanic	White
Patient's Primary Language (Please CIRCLE your selection):	English	Spanish	Other	
Patient's Ethnicity (Please CIRCLE your selection):	1 - Latino		2 - Non-Latino	

EMPLOYER INFORMATION	
Patient Employment Status (Circle Choice): Full Time, P/T, Retired, Not-Employed, Student	Retirement Date:
Employer/School Name:	Work Phone:
Employer Address:	City:
State:	Patient Occupation:

RESPONSIBLE PARTY (PLEASE COMPLETE IF THE PRIMARY INSURANCE HOLDER IS NOT THE PATIENT)		
Name of Policy Holder:	Relation To Patient:	
Policy Holder's Birthdate:	Mailing Address:	
City:	State:	Zip:
Social Security Number:	Phone:	
Employment Status (Circle Choice): Full Time, P/T, Retired, Not-Employed, Student	Retirement Date:	
Employer:	Mailing Address:	
City:	State:	Zip:
Work Phone:	Occupation:	

EMERGENCY INFORMATION	
Name:	Relation To Patient:
Home Phone:	Work Phone:

INSURANCE AUTHORIZATION

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S). I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR IT'S INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ELECTROPHYSIOLOGY ASSOCIATES, PA, AND/OR STEPHEN L. WINTERS, MD, JAY H. CURWIN, MD, ROBERT F. COYNE, MD, JONATHAN S. SUSSMAN, MD AND/OR TIMOTHY H. MAHONEY, MD FOR SERVICE(S) RENDERED.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED DUE TO MY FAILURE TO OBTAIN THE APPROPRIATE DOCUMENTATION, I AGREE TO BE RESPONSIBLE FOR PAYMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING MY CO-PAY AT THE TIME OF SERVICE AND ANY AMOUNT NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT YOUR OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF MY CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE LIMITS OF YOUR CREDIT POLICY. IN ADDITION, I HAVE RECEIVED ELECTROPHYSIOLOGY ASSOCIATES, PA's NOTICE OF PRIVACY PRACTICES.

SIGNED: ______________________________ DATE: ____________

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT

PLEASE MAKE PAYMENT OF YOUR OFFICE VISIT CO-PAY TODAY BY CHECK OR CREDIT CARD ACCORDING TO THE AMOUNT SHOWN ON YOUR INSURANCE CARD.

IF YOU HAVE YOUR INSURANCE CARDS, OR IF YOU GAVE US LEGIBLE COPIES OF YOUR INSURANCE CARDS (FRONT & BACK SIDES), THEN YOU DO NOT NEED TO COMPLETE THE FOLLOWING SECTIONS. OTHERWISE, WE NEED THE INFORMATION BELOW.

PRIMARY INSURANCE INFORMATION

Carrier-Plan:	Address:	
Policy#:	Group #:	
Plan Phone Number:	Insured Name:	
Patient Relation To Insured:	Insured Birthday:	
Insured's Mailing Address:	City:	
State:	Social Security Number:	
Insured's Employment Status:	Insured's Employer:	
Employer Address:	City:	State:
Work Phone:		
Is This The Result Of An Accident? Y or N	Date Of Accident:	
Auto Accident: Y or N	Other Accident: Y or N	Work Related: Y or N
Claim #:		

SECONDARY INSURANCE INFORMATION

Carrier-Plan #:	Address:	
Policy #:	Group #:	
Plan Phone Number:	Insured Name:	
Patient Relation To Insured:	Insured's Birthdate:	
Insured's Mailing Address:	City:	
State:	Social Security Number:	
Insured's Employment Status:	Insured's Employer:	
Employer Address:	City:	State:
Work Phone:		
Is This The Result Of An Accident? Y or N	Date Of Accident:	
Auto Accident: Y or N	Other Accident: Y or N	Work Related: Y or N
Claim #:		

MEDICAL BILLING & DATA PROCESSING BY:
Castlerock Management Corporation
1-800-827-4676 Fax: (973) 625-3665
Castlerock Management Corporation