



River Region Cardiology

185 Mitylene Park Lane Montgomery, AL 36117
334-387-0948 Office 334-387-0955 Fax

REFERRED BY: _____ FAMILY PHYSICIAN: _____

PATIENT'S LAST NAME _____ FIRST _____ M.I. _____

STREET ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ CELL/OTHER _____

SEX _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ - _____ - _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMPLOYER'S NAME _____

EMERGENCY CONTACT (NAME & ADDRESS) _____

RELATIONSHIP TO PATIENT _____ PHONE # _____

FINANCIAL RESPONSIBILITY: SAME SPOUSE OTHER

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ RELATION TO PATIENT _____ DOB _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE # _____

EMPLOYER _____ ADDRESS _____ CITY _____ ST _____

NAME OF INSURANCE COMPANY _____

POLICY # _____ GROUP # _____ EFFECTIVE DATE _____

MEDICARE # _____ MEDICAID # _____ PATIENT 1ST _____

SECONDARY INSURANCE _____

POLICY # _____ GROUP # _____ EFFECTIVE DATE _____

PAYMENT AGREEMENT ASSIGNMENT OF BENEFITS, RELEASE OF RECORDS AND AUTHORIZATION OF TREATMENT
I, the undersigned, promise to pay in full, to River Region Cardiology, PC for any and all charges in consideration of work done and materials furnished immediately upon such charges being incurred. Upon default, I agree to pay any rebilling charges, interest charges, reasonable legal fees, and all cost associated with the collection of this note.

I hereby authorize assignment of benefits to River Region Cardiology, PC for any medical services rendered by them. I also authorize the release of my medical records and any documentation necessary to obtain reimbursement for services rendered.

In the event that I am referred to another provider, I authorize River Region Cardiology, PC to forward my medical record as it relates to such referral to that provider. Additionally, upon my verbal request for a copy of my record and prepayment for such copies, this shall serve as sufficient authorization. A copy shall be valid as the original.

Signature of responsible party _____ Date _____

M. Luqman Ahmed, MD

Pervaiz Malik, MD

Narinder Bhalla, MD