



Anil H. Jhangiani, MD, FSCAI  
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325 N. Main Street, # 206  
Springboro, OH 45066

**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ **Email:** \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female **Ethnicity:** Hispanic/Non Hisp **Race:** \_\_\_\_\_

Marital Status:  Married  Single  Widow(er)  Divorced  Separated

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Full Time Student:  No  Yes Employer: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Guarantor (if different from above):**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Emergency contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**Insurance Information: (Please present insurance cards to office)**

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is this a work related injury? \_\_\_\_\_ Is this injury related to a motor vehicle accident? \_\_\_\_\_

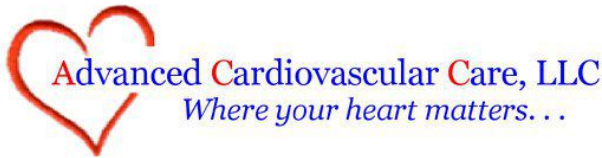
\*If yes:

Claim # \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Case worker Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Advanced Directives:**

Do you have an advance directive, (living will)? \_\_\_\_\_



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If yes, at which hospital is it filed? \_\_\_\_\_.

**How did you hear about our office?**

Friend/family \_\_\_\_\_ Physician: \_\_\_\_\_ Advertisement \_\_\_\_\_ other \_\_\_\_\_

Whom may we thank for your referral to our office? \_\_\_\_\_.

**Missed Appointment Policy:**

We at **Advanced Cardiovascular Care** are concerned about your health care. Not keeping scheduled appointments hinders our ability to provide quality care. **Advanced Cardiovascular Care** requires a 24 hour notice for all cancellations. This allows us to offer another patient your time slot in the event you can not keep it. If you do not provide a 24 hour cancellation notice you will be charged for the visit. This charge is not payable by your insurance carrier and will be your responsibility. Charges may vary from \$50.00 to \$150.00 depending on the purpose of the visit.

**Co-Payments:**

All co-payments and deductibles are due at the time of service. Additional charges will apply if you must be billed.

**Authorizations:**

I authorize examination, diagnosis, and general treatment (including but not limited to, the use of x-ray and other Non-invasive procedures such as diagnostic tests) to be performed by the physicians and staff of **Advanced Cardiovascular Care**. I realize that if a medical procedure is required, I will be given additional information.

I understand that as part of my healthcare, this practice originates and maintains health records and radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. **Advanced Cardiovascular Care** will retain the health records and radiology films even if my healthcare provider(s) leave the practice.

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment/participates.

**Financial Agreement:**

I understand the bill is my responsibility. I assign and authorize payments be made directly to **Advanced Cardiovascular Care** of all insurance benefits and agree to pay any balance due. If account is not paid when due, reasonable collection and court costs will be paid by the undersigned and that an interest rate of 1% per month will be charged on any balance outstanding after 90 days.

I understand that I will be responsible for any additional fees incurred from the following:

- Returned Checks
- Missed Appointments
- Non-payment of co-pays or deductibles at time of service
- Copies of Medical Records

By signing the line below, you are stating that you have read and agree to all portions of this contract and ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's representative

\_\_\_\_\_  
Representatives relationship to patient.  
A copy of legal authority to act for the Patient must be presented.