Advanced Cardiovascular Care, LLC
Where your heart matters. . .

Anil H. Jhangiani, MD, FSCAI
James Laws, DO
Josiah J. Hannen, PA-C
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.