

Patient Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Work Phone # \_\_\_\_\_

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

Emergency Notification Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ Address and Phone: \_\_\_\_\_

Name of Doctor Who Referred you to us: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please Read and Sign the Following:**

I request that payment of all authorized Medicare and Health Insurance benefits be assigned to Dr. Crepps, Dr. Hurlbert, Dr. Dittrich, or Dr. Kissell for any services furnished me by that physician. I authorize Colorado Springs Vascular to release my medical information to health care entity's for coordination of treatment and health care plans to determine benefits payable for related services.

I understand that I am financially responsible for all medical bills incurred and all collection expenses that may become necessary to collect those bills whether or not paid by insurance.

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date

\_\_\_\_\_  
Name Date