

Cardiovascular Specialists of Frederick, LLC
 180 Thomas Johnson Drive Suite 202
 Frederick, MD 21702
 301-631-6877

John A Vitarello, M.D., F.A.C.C.
 Edward P. Riuli, M.D., F.A.C.C.
 Nirmal K. Shah, M.D., F.A.C.C.
 Aimee Park, M.D., F.A.C.C.

Stephen G. Williams, M.D., F.A.C.C.
 Sunil Sinha, M.D., F.A.C.C.
 Maya J. Salameh, M.D.
 Anwar K. Malik, M.D., F.A.C.C.
 Bhavin M. Patel, D.O.

PATIENT REGISTRATION
 PLEASE PRINT CLEARLY

PATIENT NAME First M.I. Last			Please circle one: Male Female		DATE OF BIRTH	AGE	PATIENT SOCIAL SECURITY NUMBER	
Street Address					City		State	Zip Code
Email Address			Home Phone		Work Phone		Cell Phone	
Patient's Employer			Employment Address				Occupation	
Emergency Contact					Relationship to patient		Emergency contact Phone #	
Financially Responsible Person's Name First M.I. Last					Responsible person's address			Phone number
Race	Ethnicity	Language	Name of Primary Care Physician				PCP Phone number	

Insurance Information

Primary Insurance Company name and address			Policy holder (Circle One) Self Spouse Parent		Policy Number	Group Number
Policy Holder's Name		Policy Holder's SSN	Policy Holder's DOB		Group Name (Employer)	
Secondary Insurance Company Name and address			Policy Holder (Circle One) Self Spouse Parent		Policy Number	Group Number
Policy Holder's Name		Policy Holder's SSN	Policy Holder's DOB		Group Name (Employer)	

PATIENT'S AUTHORIZATION

I, _____, hereby authorize Cardiovascular Specialists of Frederick, LLC to release any necessary information, including medical information that may be necessary to request claim reimbursement to any company to whom claims have been submitted. I permit a copy of this form, my insurance authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payment to be made payable to Cardiovascular Specialists of Frederick, LLC.

I understand if my account becomes assigned to a collection agency, I agree to pay collection agency fees of 22%, court costs, and attorney fees. Allowed by Law interest can accrue in the amount of 18%.

Signature of Patient or Authorized Person _____ Date _____