

KETTERING CARDIOTHORACIC & VASCULAR SURGEONS, INC.

Peter M. Pavlina, M. D.
Karl J. Borsody, M. D.

Thomas J. Merle, M. D.
Bruce H. Rank, D. O.

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ SS#: _____ BIRTHDATE: _____

SEX: M/F MARITAL: MARRIED/ WIDOW / SINGLE SPOUSES NAME: _____

EMPLOYER: _____ WORK NUMBER: _____

REFERRING MD: _____ FAMILY MD: _____

CLOSEST FRIEND/RELATIVE NAME AND PHONE: _____
(Someone who does not live in the same household)

I hereby authorize release of information to my insurance companies. I understand I am responsible for my bill. I authorize payment directly to my Physician. I authorize use of this form on all of my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies. I understand that there will be a \$25.00 charge for any copayment not paid at time of visit.

I hereby authorize release of medical records or copies of such, and request that they be mailed or faxed to Kettering Cardiothoracic and Vascular Surgeons, Inc. to carry out treatment, payment, and healthcare operations. I also authorize release of my medical records or copies of such from Kettering Cardiothoracic and Vascular Surgeons, Inc. to other healthcare providers to carry out treatment, payment and healthcare operations.

SIGNATURE: _____ DATE: _____

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**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT**

I, _____ (print name), hereby acknowledge that I was offered a copy of the Notice of Privacy Practices issued by Kettering Cardiothoracic and Vascular Surgeons, Inc. on the date indicated below.

SIGNATURE: _____ DATE: _____

NAME OF PATIENT (if other than above): _____

RELATIONSHIP TO PATIENT: _____
(If parent/guardian or other personal representative of the Patient please indicate type of relationship)

May we leave a message on an answering machine and/or with a family member: Y N

WITNESS: _____ DATE: _____