Patient Financial Information

T. Scott Jennings, MD (843) 556-4380 Ward A. Katsanis, MD

Patient's Full Name_____

Financially Responsible Party:

Name: _____

Address: _____

Phone ( ) _____-_____ Work Phone ( ) _____-_____

Responsible Party's Signature _____

Primary Insurance Information:

Insurance Name _____
Name of Insured _____Insured's SSN _____-____-_____
Insured's Date of Birth ____/____/_____
Insured's Relationship to Patient _____

Secondary Insurance Information:

Insurance Company _____
Name of Insured _____Insured's SSN _____-____-_____
Insured's Date of Birth ____/____/_____
Insured's Relationship to Patient _____

Note: Accurate insurance information is vital for your financial responsibility to this office and correct scheduling of subsequent tests or procedures. If insurance information is incorrect, we will require collection of payment in full at the time of service; and subsequent scheduling of tests or procedures may be affected.

_____*please initial*

I understand that insurance is filed as a courtesy and that any charges not covered by my insurance will be the responsibility of the above designated person. _____*please initial*

I understand that if I miss an appointment for which I did not call to cancel or reschedule, that I may be billed a fee for a "No Show Visit". _____*please initial*

I further understand that I will be responsible for any collection and/or legal fees and monthly interest accrued due to non-payment.
Accrued interest rate =18% per year. _____*please initial*

I authorize Carolina Center of Gynecologic Oncology to file a claim to my insurance and/or Medicare for services provided and to accept assignment for payment of this claim. I also authorize release of any medical records needed for processing my claims(s) and for coordination of care with other healthcare providers/facilities.

Patient's Signature: _____ ***Date***_____