

Today's Date: \_\_\_\_\_ If applicable, start date of your Dialysis: \_\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_

Patient's name as it appears on your insurance card. All records will appear with that name.

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

SEX: MALE / FEMALE                      MARITAL STATUS: MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_

SPOUSE DATE OF BIRTH: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF DIALYSIS CENTER (if applicable): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

NAME: \_\_\_\_\_

PHONE #: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY THAT ALL CHECKS FOR MY MEDICAL SERVICES PROVIDED BY KEVIN D. NOLAN, M.D. AND/OR WILLIAM F. OPPAT, M.D. AND/OR TAMER BOULES, M.D. AND/OR PRITHAM REDDY, M.D. BE PAYABLE AND MAILED TO:

COMPREHENSIVE VASCULAR CARE  
22250 PROVIDENCE DRIVE, SUITE 555  
SOUTHFIELD, MI 48075

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE DR. NOLAN AND/OR DR. OPPAT AND/OR DR. BOULES AND/OR DR. REDDY TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

**I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ALL PROFESSIONAL SERVICES RENDERED.** I HEREBY AUTHORIZE PAYMENT TO COMPREHENSIVE VASCULAR CARE, P.C. FOR SURGICAL AND/OR MEDICAL BENEFITS. I HAVE READ AND COMPLETED ALL THE INFORMATION ON THIS FORM. I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY STATUS ON THE ABOVE INFORMATION.