



# **SKYLINE CARDIOVASCULAR INSTITUTE, PLC**

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## **SPOUSE INFORMATION**

Spouse name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Spouse's employer name, address and phone: \_\_\_\_\_

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## **RESPONSIBLE PARTY INFORMATION**

*(Complete this section only if you would like primary contact from our clinic to be someone other than yourself.)*

Contact name (First, MI and Last): \_\_\_\_\_

SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

Employer name and phone: \_\_\_\_\_

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## **Please read the following release of information, then sign and date.**

I agree to and authorize medical treatment as deemed necessary by the Skyline Cardiovascular Institute, PLC. I hereby authorize the Skyline Cardiovascular Institute, PLC to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Skyline Cardiovascular Institute, PLC all insurance benefits payable to me by my insurance company, not to exceed the charges billed. I understand that I am financially responsible for any amount that is not covered by my insurance and this authorization. The Skyline Cardiovascular Institute, PLC can not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his or her account is turned over to an attorney, the undersigned shall be responsible for all costs of collection, including out of pocket expenses, court costs and attorney fees.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Skyline Cardiovascular Institute, PLC for any services furnished me by the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services.

Signed by patient or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_