

PATIENT AUTHORIZATION FORM
FIRST-CALL MEDICAL, INC.

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FCM Office Use Only

R# _____ E _____

I# _____ B _____

- HOLTER**
- 30-DAY EVENT**.....
- PACEMAKER CHECK**
- BLOOD PRESSURE ...**

START DATE & TIME: _____ **END DATE:** _____

MONITOR NAME & SERIAL #: _____

PATIENT INFORMATION:

LAST NAME: _____

FIRST: _____ MI: _____

BIRTHDATE: ____/____/____ SEX: _____

SOCIAL SECURITY # _____

IS THE PATIENT IN A SKILLED FACILITY (RN HOME)? SITE
NAME & ADDRESS: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

E-MAIL: _____

PRIMARY INSURANCE:

MAIL CLAIMS TO: _____

POLICY/GROUP # _____

ID # _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S SS#: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:
SELF SPOUSE: CHILD:

SECONDARY INSURANCE:

MAIL CLAIMS TO: _____

POLICY/GROUP # _____

ID # _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S SS#: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:
SELF: SPOUSE: CHILD:

Practice Name:
Address:
City:
State: Zip:
Phone: Fax:
Email:

DIAGNOSIS AND/OR INDICATIONS FOR TEST:

PRINT PHYSICIAN NAME AND UPIN #

PHYSICIAN SIGNATURE: _____

I authorize any holder of medical or other information about me to release to the carrier(s) listed above any information needed to process this claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for technical component cardiac service to First-Call Medical, Inc., which accepts assignment on this claim. I acknowledge that any services not covered by my insurance will be my responsibility. I also acknowledge responsibility for the assigned monitor to be returned in proper working order upon completion of service. Failure to do so will result in a charge of \$495 directly to me to cover the replacement costs of the monitor. I have read the Notice of Privacy Practices and Patient Authorization for Disclosure of Protected Health Information materials

PATIENT SIGNATURE: _____ **DATE:** _____