

**Consulting Cardiologists, PC**  
**PATIENT REGISTRATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ LANGUAGE: ENGLISH \_\_\_\_\_ SPANISH \_\_\_\_\_ REFUSED \_\_\_\_\_

RACE: WHITE \_\_\_\_\_ BLACK, AFRICAN AMERICAN \_\_\_\_\_ NATIVE HAWAIIAN \_\_\_\_\_

ASIAN \_\_\_\_\_ AMERICAN INDIAN/ALASKA NATIVE \_\_\_\_\_ REFUSED \_\_\_\_\_

ETHNICITY: HISPANIC OR LATINO \_\_\_\_\_ NOT HISPANIC OR LATINO \_\_\_\_\_ REFUSED \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOW/WIDOWER \_\_\_\_\_ DIVORCED \_\_\_\_\_

TELEPHONE: HOME # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL# \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS; (IF DIFFERENT): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ RETIREMENT DATE: \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE? \_\_\_\_\_

WHO IS YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ARE YOU CURRENTLY IN ACTIVE MILITARY SERVICE? YES \_\_\_\_\_ NO \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

DOES EITHER INSURANCE REQUIRE A REFERRAL FROM A PRIMARY CARE PHYSICIAN? YES \_\_\_ NO \_\_\_

IS THIS A WORKERS' COMPENSATION CLAIM? YES \_\_\_ NO \_\_\_

1. All co-pays, deductibles, co-insurance, previous balances and fees for non-covered services are due at the time of your visit. You will be responsible for all collection and attorney fees associated with the collection of your account.
2. When requested, we will be happy to provide you with a statement of your account to file with a secondary or tertiary insurance carrier.
3. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If Medicare is primary, please notify Medicare of your supplemental insurance/medigap plan. Medicare will cross-over the co-insurance and deductible to many insurance companies. This does not guarantee your supplemental plan will pay for the co-insurance.
4. As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to "routine", "non-covered", or "deemed medically unnecessary." In the event your insurance company does not cover your services, you will be responsible for payment of these services. **(This statement does not apply to Medicare patients.)**

**Consulting Cardiologists, PC**

**CONSENT FOR TREATMENT AND RELEASE OF INFORMATION**

I AUTHORIZE Consulting Cardiologists, PC (“CCPC”) to perform medical treatment.

I CONSENT to CCPC’s use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for tests (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to CCPC, when needed for the purposes of TPO.

I CONSENT to CCPC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1. \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_

**I have been given a copy of CCPC’s Privacy Notice.**

**I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.**

**I understand that should I choose not to consent to the terms and conditions of CCPC’s Privacy Notice, the practice has the right to and will withhold treatment except where required by law.**

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

PATIENT’S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

INSURED OR GUARDIAN’S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.**