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.