

**Consulting Cardiologists, PC**

**PATIENT REGISTRATION & CONSENT FORM**

NAME: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ SS# \_\_\_/\_\_\_/\_\_\_

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

STREET ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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

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

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

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

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: \_\_\_\_\_

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

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

**INSURANCE INFORMATION**

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

SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

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

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

SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT): \_\_\_\_\_

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

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

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

1. Your insurance is filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility.
2. All copays, 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 fees associated with the collection of your account.
3. We will be happy to provide you with a statement of your account, when requested, to file with a secondary or tertiary insurance, once your account is paid in full. We will file secondary insurances, when needed, if required by a specific contract.
4. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If your Medicare is primary, please notify Medicare of your supplemental insurance. Medicare normally forwards claims to a supplement for processing of co-insurance or deductibles. This does not guarantee your supplement will pay for these balances.
5. 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" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

**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 the opportunity to review 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'S 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.**