PATIENT REGISTRATION

Patient Name: _____ Date Of Birth: _____

SS#: _____

Circle One: Male / Female Marital Status: Single / Married

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Telephone Number: (Home) _____ (Cell): _____ (Work): _____

What is the BEST way to contact you? _____

Emergency Contact: _____ Relationship: _____

Contact Telephone Number: _____

List any persons who you authorize to discuss or receive your medical information on your behalf:_____

_____

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Telephone #:_____

Employer Address: _____ City/State: _____

Zip: _____ Patient's Occupation: _____

INSURED PERSON (IF NOT PATIENT)

Name: _____ Telephone Number: _____DOB: _____

Employer Street Address: _____ City/State: _____

Zip: _____ Relationship to Patient: _____

INSURANCE

Primary Ins. Co. Name: _____

ID#: _____ Group#: _____ Phone#: _____

Secondary Ins. Co. Name: _____

ID#: _____ Group#: _____Phone#: _____

ADDITIONAL INFORMATION

Referring Doctor: _____ Primary Care Doctor: _____

I agree that I have been given the opportunity to read and/or receive a copy of Athens Cardiac Clinic, PC, Notice of Privacy Practices.

I ALSO AGREE NOT TO ELECTRONICALLY (AUDIO/VIDEO) RECORD ANY PART OF MY VISIT TODAY, WITHOUT EXPRESS PRIOR WRITTEN AUTHORIZATION BY THE MANAGEMENT OF ATHENS CARDIAC CLINIC, PC. IF THIS OCCURS, I AGREE NOT TO USE THIS MATERIAL IN ANY WAY (FOR EXAMPLE POSTING ON SOCIAL MEDIA, MEDICOLEGAL PURPOSES OR OTHER PUBLICLY ACCESSIBLE MANNER) OTHER THAN IMMEDIATE PERSONAL REVIEW. THIS AGREEMENT IS TO PROTECT THE PRIVACY AND LEGAL RIGHTS OF BOTH PARTIES i.e. PATIENT AND CLINIC. I understand my medical information/record will be available to me and my referring/other consulting physicians as needed/requested.

Patient/Guarantor Signature _____ **Date** _____

Release of Information: Athens Cardiac Clinic, PC may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to Athens Cardiac Clinic, PC for reimbursement for services rendered and (2) any health care provider for continued patient care. In addition, Athens Cardiac Clinic, PC, may release information when required legally/by law enforcement or public health authorities.

Athens Cardiac Clinic, PC may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

_____ _____

Patient or Guardian/Beneficiary (Print Name) **Patient Date of Birth**

_____ _____

Patient or Guardian/Beneficiary Signature **Signature Date**

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION AND PRIVACY PRACTICES ACKNOWLEDGEMENT

I give my authorization to use or disclose my protected health information to any health care provider who is involved with my medical treatment or services, my health insurance plan and/or medical billing clearing house who is involved with my insurance claims fulfillment.

I authorize you to release information to the following people:

Name _____ Phone _____

Relation _____

What specific information to disclose/No restriction _____

_____

Name _____ Phone _____

Relation _____

What specific information to disclose/No restriction _____

_____

I authorize the office to contact me in the following manner:

_____Home Phone
_____Cell Phone
_____Work Phone

_____Leave detailed information
_____Leave call back number only

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates who are part of the health care process. These business associates will also keep your health information confidential. I also have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____

Signature **Date**

Athens Cardiac Clinic, PC - Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

We appreciate the confidence you have shown in partnering with us to meet your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer deemed allowable. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. We may charge a deposit amount up front, which would be appropriately adjusted based on clarification from insurance.

I have read the above policy regarding my financial responsibility to Athens Cardiac Clinic, PC, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Athens Cardiac Clinic, PC. I am responsible for the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ **Date** _____
Guarantor Signature / Name _____ **Date** _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ **Date** _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Athens Cardiac Clinic, PC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Athens Cardiac Clinic, PC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ **Date** _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. We reserve the right to charge a "no-show" fee of $50.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ **Date** _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Athens Cardiac Clinic, PC. I agree to pay Athens Cardiac Clinic, PC, the full and entire amount of treatment given to me or to the above named patient at each visit, or per a payment plan established in advance and in conjunction with Athens Cardiac Clinic, PC. Patient/Guarantor

Signature _____ **Date** _____