Welcome to Athens Cardiac Clinic, PC. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with office visits that accommodate your schedule. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your verifiable insurance card/information, your appointment may need to be rescheduled unless alternate financial arrangements are made. You will be asked to fill out new registration forms periodically so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our practice. Please let our staff know if you need a financial consultation—we will provide this in a private and secure setting to help serve you in a professional and courteous manner.

We recommend you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit (or a detailed list of medication names with strength and dosing instructions). We may also be notified through your insurance company of any current/recent prescriptions, though technology does not always work perfectly!

Our office policy for a missed appointment is:

- Two (2) consecutive no-show appointments, no show for three (3) appointments or cancel for a total of four (4) appointments, you may be discharged from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. **Athens Cardiac Clinic, PC does not offer chronic pain management and will not dispense chronic pain medication** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic cardiac disease (for example, high blood pressure or hyperlipidemia), you will be given ample refills for 30 or 90 days at a time during your office visit.
    a. When you are down to a 15 day supply of medication, we ask that you call our office for refills during regular business hours. We will then refill your medication for you if you are up to date with your appointments. If not, an appointment will need to be made for a follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
    b. The on-call physician covering for the practice is available for urgent issues—routine refill requests may not be honored after-hours, and you will likely be directed to call back during regular hours.

Dr. Rohit Tongia is credentialed with Piedmont Athens Regional Medical Center at this time. He works with the many specialty physicians there. This is an important resource in meeting our goal of providing high quality care in a timely manner.

Welcome to our practice and thank you for choosing Athens Cardiac Clinic, PC for your health care needs!

As always, we welcome your feedback and suggestions for improvement.

Sincerely,

Athens Cardiac Clinic, PC—your Care Partners.

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** _____

HIPPA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

INTRODUCTION

Athens Cardiac Clinic, PC is required by law to maintain the privacy of "protected health information." "Protected Health Information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy pf protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our practice.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations.* For each category we will explain what we mean.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health services, we may need to provide to your health plan information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill your health plan for the services rendered to you, we can provide them with information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you.