Premier Cardiovascular PA

Patient Registration

First Name: _____ Middle: _____ Last: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Phone / Contact: _____

Sex: F / M Marital status: _____ DOB: _____ Social Security: _____

Referring Physician/ Phone Number: _____

Employer Name: _____

Phone #: _____

Pharmacy: _____ Phone Number: _____

Insurance Information

Please give insurance card at time of arrival. So that we may make a copy of your card.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as an original.
I authorize said assignee to release all information necessary to secure payment. I understand I am responsible for any deductable, co-insurance and or non- covered services. In the event my account is assigned to collection, I agree to pay all cost of collection including reasonable attorney fees.

_____ _____

PATIENT'S SIGNATURE DATE

Patient Name: _____ DOB: _____ Age: _____

Referring Physician: _____

Reason for visit: _____

_____

Any known Allergies: _____

Allergy to X ray dye or Contrast: _____

Please check all that applies:

List any MEDICAL DISORDER(S) which you have had or are being treated for:

___Angina/Chest pains	___Stroke	___Anemia	___Fibromyalgia
___Heart Attack	___Diabetes	___Leukemia	___Cancer (Type) _____
___Heart Murmur	___Bronchitis	___HIV	___Bleeding Disorder
___Heart Failure	___Emphysema	___Hepatitis	___Kidney Stones
___Palpitations	___Asthma	___Tuberculosis	___Kidney Failure
___Atrial Fibrillation	___COPD	___Ulcers	___Kidney Disease
___Abnormal Rhythm	___Seizures	___Liver Disease	
___Heart Disease	___Fainting Spells		
___High Blood Pressure	___Arthritis		
___High Cholesterol	___Thyroid Disease		

Check if you have had any of the following procedures:

TEST	WHEN	WHERE
_____ **Stress Test:**	_____	
_____ **Echocardiogram:**	_____	
_____ **Cardiac Catheterization:**	_____	
_____ **Angioplasty/Stenting:**	_____	
_____ **Open heart Surgery:**	_____	
_____ **Valve Surgery:**	_____	
_____ **Pacemaker/defibrillator:**	_____	

List Any Surgeries:

SURGERY	YEAR

Personal Habits:

Do you use tobacco ?: ___Yes ___No

If "NO", have you smoke before ?:_____ When did you quit ?:_____

Do you drink alcohol:_____ If yes, how much ?:_____

Recreational drugs: ___Yes ___No

Family History: Do you have any immediate family member who has had; (give relationship):

Heart Disease, Heart Attack, Heart Surgery, Angina: _____

High Blood Pressure: _____

Diabetes: _____

High Cholesterol: _____

Do you suffer from or experience:

Chest pains:	**___Yes**	**___No**	**Loss of appetite:**	**___Yes**	**___No**
Palpitations:	**___Yes**	**___No**	**Frequent heart burns:**	**___Yes**	**___No**
Irregular heart beat:	**___Yes**	**___No**	**Nausea/Vomiting:**	**___Yes**	**___No**
Fainting:	**___Yes**	**___No**	**Constipation:**	**___Yes**	**___No**
Swelling of feet:	**___Yes**	**___No**	**Frequent diarrhea:**	**___Yes**	**___No**
Shortness of breath:	**___Yes**	**___No**	**Vomiting blood:**	**___Yes**	**___No**
If Yes:			**Blood in the stools or**		
During walking	**___Yes**	**___No**	**black stools:**	**___Yes**	**___No**
Climbing stairs	**___Yes**	**___No**	**Burning when urinating:**	**___Yes**	**___No**
Lying down	**___Yes**	**___No**	**Blood in urine:**	**___Yes**	**___No**
Frequent cough/sputum:	**___Yes**	**___No**	**Getting up frequently at**		
Coughing up blood:	**___Yes**	**___No**	**night to urinate:**	**___Yes**	**___No**
Wheezing:	**___Yes**	**___No**	**Excessive thirst/urination:**	**___Yes**	**___No**
Fever/Chills:	**___Yes**	**___No**	**Frequent headaches:**	**___Yes**	**___No**
Loss of weight:	**___Yes**	**___No**	**Excessive weakness**	**___Yes**	**___No**
Do you bleed easily:	**___Yes**	**___No**	**Seizures:**	**___Yes**	**___No**
Any rashes:	**___Yes**	**___No**	**Dizziness:**	**___Yes**	**___No**
Muscle ache:	**___Yes**	**___No**	**Glaucoma:**	**___Yes**	**___No**
Joint swelling:	**___Yes**	**___No**	**Vertigo:**	**___Yes**	**___No**
Joint redness:	**___Yes**	**___No**	**Anxiety:**	**___Yes**	**___No**
			Depression:	**___Yes**	**___No**

OFFICE BILLING POLICY

As a courtesy, we submit to all insurance carriers for all patients. Even if we do not participate with the plan. Any applicable co-pay will be collected at time of service. For all others, payment are expected at the time of the visit unless other arrangements are made in advanced of the appointment.

We request a copy of all insurance card(s)

PATIENT RESPONSIBILITY STATEMENT

Regardless of our participation status with your insurance carrier, it is not possible for us to be updates and aware of any changes in your policy. It is the patient's responsibility to update our office upon check-in or over the phone of any changes to your insurance.

1) I understand that I am financially responsible for all services rendered from this day forward, and that if Premier Cardiovascular PA submits claims to my insurance carrier on my behalf, I am responsible for payment of any deductable, co-payments and out-of-network expenses which may apply. I further understand that if Premier Cardiovascular PA does not participate with my insurance and submit a claim on my behalf, I am responsible for any amount over and above what the insurance carrier allows, and the payment arrangement can be made with the billing department.
2) I agree to promptly turn over to Premier Cardiovascular PA any payments sent directly to me by my insurance carrier for services provided by Premier Cardiovascular PA and for which there is an outstanding balance on my account.
3) I understand that I am currently insured under a plan, or covert to plan in the future, and a referral from my primary physician is required. It is my responsibility to obtain the referral prior to my visit and to make certain that it is current, complete and include an authorization for any testing and/or surgery which may be indicated. I further understand that if I have not obtained a referral at the time of my appointment I may 1) Cancel and reschedule for a later date without any penalty or 2) Choose to be seen without prior approval and make payment for services at the time of visit. I also fully understand that if Premier Cardiovascular PA participates with my insurance carrier and my plan provides out- of- network benefits for unauthorized visits a claim will be submitted to my carrier and I will be responsible for any co-payments and/or deductable which may apply. Should I choose to cancel my appointment I understand that the appointment will be after the necessary referral is received and when opening is available.
4) I understand Premier Cardiovascular PA will charge a $35.00 fee for all returned checks and that a $25.00 "NO SHOW" will apply for all appointment cancelled without a 24 hour notice at the time of a 2nd occurrence.

_____ _____

DATE SIGNATURE OF PATIENT OR GUARDIAN

Summary of Notice of Privacy Practices

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). The Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care " operations " such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionist, billing services and other who assist in the operations of our practice. We may call you to remind you of appointments and may leave messages on your answering machine if you have one. We may also disclose information to your family about location, general condition or death. If you are available and able, we may ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by the state and federal law, and certain other purposes.
2. **Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. **Your Health Information Rights.** You have a number of rights under state and / or federal law, which are subject to the terms and conditions specified in the Notice.
   A) You may request restrictions on certain uses and disclosures of your information
   B) You may request that you receive your information from us in a certain way.
   C) You may inspect and copy your medical records.
   D) Your may request amendment to any record you believe is inaccurate.
   E) You may request an accounting of disclosures made of your records.
4. **Change to the notice.** We reserve the right to change the Notice. If we do, WE will post it in our office and provide a copy upon request.
   Complaints. You may file a complaint to our Privacy Official or with the federal government as detailed in our Notice. You will not be penalized for filling any compliant.

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____ DOB: _____

I hereby acknowledge that I received a copy of Privacy Practices of this medical practice. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print name: _____ Phone#: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For office Use Only:

_____ Signed form received by: _____

_____ Acknowledgement refused:

_____ Reasons for refusal: _____