Cardiovascular Centers of America
INTERNAL MEDICINE & CARDIOVASCULAR DISEASES
1609 SW 17th street, Ocala, FL 34471 Phone: 352-401-9888 Fax: 352-401-9852

PATIENT REGISTRATION FORM

PATIENT INFORMATION *(Please write information about the patient here)*

Patient Name: **Sex:** □Male □Female	**Referring Provider:**
Patient's home address:	**Referring Provider's Address:**
City: _____ **State: _____** **Zip Code: _____**	**Employer's Name:**
Contact Telephone Numbers: **Home:_____** **Cell: _____** **Work: _____**	**Employer's Address:**
Marital Status: □Married □Single □Divorced □Separated □Widowed	**Employment Status:** □Full-time □Part-time □Retired □Other
Date of Birth: _____/____/____	**Patient Social Security Number:** **_____/_____/_____**
Age: _____	**Patient Drivers License Number:**

INSURANCE INFORMATION ***(Please write information about the patient's insurance here)***

Primary Insurance Company:	**Secondary Insurance Company**
□Medical □Dental □Workers Comp	□Medical □Dental □Workers Comp

PRIMARY AND SECONDARY INSURANCE CARDS MUST BE PRESENTED AT TIME OF VISIT.

I attest that the above information is true to the best of my knowledge.

X_____ _____
Signed (patient, or guardian if patient under 18 years of age) Date

Cardiovascular Centers of America
Financial Policy

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, I need your assistance and your understanding of my payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.
My office accepts cash, personal check, Visa, MasterCard, and Visa Debit. Returned checks less than $50.00 is subject to a service charge (per Florida statute 832.80) of $25.00. Checks between $50.00 and $300.00 have a fee of $30.00. For checks greater than $300.00, the fee is $40.00. You will also lose your privilege to write checks in my office.

CANCELLED APPOINTMENTS- Patients who do not cancel appointments may be discharged from the practice after three no-shows.

BLUE CROSS/BLUE SHIELD PPC COVERAGE- CO-PAYMENTS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF SERVICE.

MEDICARE- Your deductible is due at the time of service. If you have already paid your deductible (please bring your EOB showing you have met your deductible), and if Medicare is your only coverage, we will charge you 20% of the Medicare allowable charges. Since I am a Medicare provider, I will file your Medicare claim. If you have a secondary insurance company of which I am a provider, I will file your claim with the secondary and bill you only for the remaining balance of allowable charges. If you have a secondary insurance, please check with our insurance billing department to see if I file with that company. If I do not know the allowable charge for a specific service, I will bill you after Medicare pays.

MEDICAID - There is a $2.00 co-payment due for each visit, except for children and pregnant women.

FINANCIAL AGREEMENT- I and my office will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer if applicable, and the insurance company. I and my office are not part of that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals).

I must emphasize that as your medical care provider, my relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account over 90 days, including those that insurance has not paid, collection action will be taken. I realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I have read and understand the above Financial Policy.

_____ _____
Signature (patient or guardian if patient under 18 years of age) Date

Cardiovascular Centers of America

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Cardiovascular Centers of America may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cardiovascular Centers of America's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Cardiovascular Centers of America reserves the right to revise its Notice of Privacy Practices atany time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

Privacy Officer
Cardiovascular Centers of America
1609 SW 17th street, Ocala, FL 34471Phone: 352-401-9888 Fax: 352-401-9852

With my consent, Cardiovascular Centers of America may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and employee statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Cardiovascular Centers of America's use anddisclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Cardiovascular Centers of America may decline to provide treatment to me.**

_____ _____
Signature (patient, or guardian if patient under 18 years of age) Date

_____
Patient Name

_____
Print Patient Name or Legal Guardian Name

Cardiovascular Centers of America

NOTICE RECEIPT ACKNOWLEGEMENT

Purpose: This form is used to confirm that an individual has received Cardiovascular Centers of Americas notice of Privacy Practices.

I, _____, acknowledge that I have received Cardiovascular Centers of America's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of PrivacyPractices.

_____ _____

Signature Date

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Print Patient Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Patient Number: _____

Social Security Number: _____/_____/_____