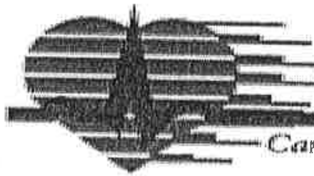

SOUTHEAST CARDIOLOGY

Caring for the heart, from the heart

NEW PATIENT INFORMATION

Demographic

Patient's Name: ______________________ Date of Birth: __________ Sex: ______

Race: American Indian/Alaska Native Asian Black/African American

Hispanic/Latino Native Hawaiian/Pacific Islander White/Caucasian

Ethnicity: Hispanic or Latino Not Hispanic or Latino Preferred Language: __________

Address: ______________________ City: __________ State: ________

Zip Code: ________ Home Phone: ( ) __________ Cell Phone: ( ) __________

Email Address: ______________________ Social Security Number: __________

Emergency Contact Information

Emergency Contact: ______________ Phone: ( ) __________ Relationship: ______

Physician Information

Referring Physician: ______________________ Family Physician: ______________________

Pharmacy Information

Preferred Pharmacy: ______________________ City: __________ State: ________

Employment Information

Employment Status: Employed Unemployed Full Time Student Child Retired

Patient's Employer: ______________________ Work Phone: ( ) __________

Insurance Information

Primary Carrier: ______________________ Contract Number: __________

Secondary Carrier: ______________________ Contract Number: __________

If insurance policy holder is other than the patient: ______________________

Name Date of Birth

Is this patient a resident of nursing home: Yes No

Is this patient under hospice care: Yes No

Revised 12/2017

Patient Consent Form for the Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you, including information that may be deemed sensitive, for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting our Privacy Officer, the Administrator, Jennifer Childers at (334)712-1929 or (800)239-1929 toll free. She is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our form entitled Request for Restriction on Use and Disclosure of Patient Information.

If you do not sign this consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this consent form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization to Release Health Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

Print Patient Name: ______________________________ Date of Birth: ________________

Patient Signature: ______________________________ Date: ____________________

*** *Permission Regarding Disclosure of Your Health Information* ***

I hereby authorize Southeast Cardiology Clinic, Inc. to speak to the individual(s) named below regarding my protected health information (optional):

Name: ___________________________ Relationship to Patient: ______________________

Address: ____ Phone: (   ) __________

Name: ___________________________ Relationship to Patient: ______________________

Address: ____ Phone: (   ) __________

SOUTHEAST CARDIOLOGY CLINIC, INC.

PAYMENT POLICY

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is the patient's responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. Also, all coinsurance and deductible are due at time of service. Payment of these items is part of your contract with your insurance company. Failure on our part to pay co-payments, coinsurance, and deductibles can be considered breaking your financial agreement. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor or nurse practitioner. We must obtain a copy of your drivers' license or other picture ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission.** We will submit your claims to your insurance as a courtesy. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis.

I understand and accept responsibility for Southeast Cardiology Clinic, Inc.'s payment policies. I understand that while this consent is voluntary, if I refuse to sign this consent, Southeast Cardiology Clinic, Inc. can refuse to treat me. I understand this authorization can only be revoked in writing, and if I revoke my consent, such revocation will not affect any actions that Southeast Cardiology Clinic, Inc. took before receiving my revocation.

I hereby certify that the information given in applying for payment under Title XVII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration, the State of Alabama, Georgia, or Florida or their intermediaries, carriers or agents any information needed to determine these benefits for related services.

____
Signature of Patient or Patient's Representative

____
Date

____
Relationship of representative to patient