Patient Registration Form

Please print clearly and answer ALL questions

PATIENT INFORMATION

Title Name	First	M.I.	Last
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	SS #

Date of Birth	Age	Sex (circle one) M F	Race	Marital Status	Spouse's Name
Address	City	State	Zip		

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name/ First	M.I.	Last		
Address	City	State	Zip	
Home Phone	Work Phone	SS #		
Employer	Address	City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Name	ID #	Group #	Date of Birth
Secondary Insurance Company			
Address	City	State	Zip
Insured's Name	ID #	Group #	

Is this visit a result of a work injury? Y N	Date Injured	Industrial Claim #
Is this visit a result of a car accident? Y N	Date of Accident	Attorney Name:
Drug Allergies (list)		
Who can we thank for referring you to us?		
Other		

WE FILE YOUR INSURANCE AS A COURTESY. YOU ARE STILL RESPONSIBLE FOR YOUR BALANCE. I authorize that payment of medical benefits be made to Delta Cardiovascular Center on any claim submitted for services rendered to me. I understand medical information obtained by this authority will be used to determine eligibility for insurance and eligibility for benefits. I certify that the above statement are true and correct to the best of my knowledge.

OUR CANCELLATION POLICY: **We require 24 hours notice for cancellation of appointments. Please note that a $50.00 NO SHOW FEE will be charged for the first missed visit; $25.00 for the second. A $200.00 NO SHOW FEE will be charged for a missed stress test appointment. IF YOU HAVE 3 NO SHOWS WE WILL NOT RESCHEDULE AN APPOINTMENT OR IF YOU FAIL TO PRE-REGISTER FOR CARDIAC CATHETERIZATION, PACEMAKER DEVICE IMIPLANTATION OR OTHER OUTPATIENT PROCEDURE YOU WILL NOT BE RESCHEDULED.**

PLEASE READ AND SIGN ON THE REVERSE SIDE OF THIS FORM.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Certified Medical Specialists originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Certified Medical Specialists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Certified Medical Specialists reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Certified Medical Specialists change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Certified Medical Specialists** for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ Date:_____
Patient, Parent or Guardian

CONSENT FOR CARE

I hereby give my consent for treatment to **Certified Medical Specialists,** including treatment or services, and which may include but not be limited to laboratory procedures, examination, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patient's physician.

Signature:_____ Date:_____
Patient, Parent or Guardian

If I am a minor or filing benefits through my parent's/guardian's insurance, I authorize you to release information concerning my medical care to my parent(s) or legal guardian.

Signature:_____ Date:_____
Parent/Legal Guardian

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize **Certified Medical Specialists** or any person designated by them, to obtain/review copies of my medial records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

Signature:_____ Date:_____
Patient, Parent or Guardian

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to **Certified Medical Specialists** for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

Signature:_____ Date:_____
Patient, Parent or Guardian

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize **Certified Medical Specialists** to leave a message regarding pending appointments and/or tests at my residence. You may notify me of lab/test results, matters relating to prescriptions, my physician or his/her representative by leaving a message (check all that apply) on my answering machine/home voice mail _____, with my spouse _____, or a family member (please specify name of family member)_____.

Signature:_____ Date:_____
Patient, Parent or Guardian

	POINTS
How soon on waking do you smoke your first cigarette? Within 5 minutes	3
Within 6 to 30 minutes	2
Within 31 to 60 minutes	1
After 60 minutes	0
How many cigarettes do you smoke a day? 31 or more	3
21 to 30	2
11 to 20	1
10 or fewer	0

SCORE

5 – 6 = High nicotine dependence

3 – 4 = Moderate nicotine dependence

0 – 2 = Light nicotine dependence

Adapted from Heatherton TF et al. Br J Addict. 1991[18] Malin R. Am Fam. Physician. 2002.[21]

Medication Log

Patient Name_____ Birthdate_____

Home Phone_____ Work Phone_____ Occupation_____

Pharmacy_____ Pharmacy Phone_____

MEDICAL/ALLERGY ALERTS:

DATE Rx	MEDICATIONS	DOSAGE	QTY.	FREQ.	REFILLS DATE AND INITIAL				STOP DATE

Medication Log