



PATIENT REGISTRATION INFORMATION
PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ SEX M F SOCIAL SECURITY _____

MARITAL STATUS S M W D Other _____ SPOUSE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

PRIMARY CARE PROVIDER _____

RACE White Black Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native Hispanic Other

ETHNICITY Hispanic/Latino Non-Hispanic/Latino Unreported/Refused

LANGUAGE English Spanish French Arabic Chinese Sign Language

EMPLOYER _____ WORK PHONE _____

Responsible Party Information (for patients under 18 and other dependent patients)

Name: _____ Relationship to patient: _____
Last First Middle Initial

Social Sec. #: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: F M Phone: _____ Home Cell Other
MM/DD/YYYY

Emergency Contact

Name: _____ Phone: _____ Relationship to patient: _____

<p>Patient's Insurance Information</p> <p>Primary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>	<p>Secondary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>
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Patient Registration Form (Continued)

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Patient Central. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services or vaccinations. Charges for paperwork are not covered by insurance, and will be charged a \$30 fee. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**



Signature of Patient or Legal Guardian

Date

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.



Signature of Patient or Legal Guardian

Date

Notice of Narcotic Policy

I understand that Patient Central does not prescribe narcotic medications. In the event I should need this type of medication, I understand I will be referred to a specialist or pain management clinic. Patient Central does not prescribe long term pain medications. I fully accept and will comply with this policy of Patient Central.



Signature of Patient or Legal Guardian

Date

Missed Appointments / Same Day Cancellation Policy

I also acknowledge I am responsible for payment of the fees listed below relating to missed appointments and same-day cancellations.

1st - No Charge

2nd - \$25

3rd - \$100, also may be subject to immediate discharge from our office.

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.



Signature of Patient or Legal Guardian

Date

Patient Name: _____ DOB: _____ Date: _____
MM/DD/YYYY

Reason for being seen today: _____

Have you had any recent international travel? Yes No

Is this a follow up visit? Yes No

Do you need medication refills? Yes No

Allergies:

Are you allergic to any medications? Yes No
 If Yes, please list all.

Do you have any other allergies? Yes No
 If Yes, please list all.

Medications:

Are you taking any medications, prescription or over the counter, right now? Yes No

If Yes, please list all medications.

Medication Name	Strength	Quantity taken at one time	Times per day taken

Please list any other medications on the back of this form.

Social History:

Do you use tobacco?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, on occasion	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Do you drink alcohol?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, socially	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Do you use illegal drugs?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, socially	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Are you currently employed?	<input type="checkbox"/> Yes, full time	<input type="checkbox"/> Yes, part time	<input type="checkbox"/> No, retired	<input type="checkbox"/> No, other

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Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

Condition	Yes	No	Relative	Condition	Yes	No	Relative
Diabetes				Osteoarthritis			
High Blood Pressure				Rheumatoid Arthritis			
Heart Disease				Heart Attack/ Murmurs			
Cancer				Thyroid Disease			
Type				High Cholesterol			
Kidney Disease				Liver Disease			
Dementia				Stroke			

Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

Yes No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

Yes No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?

Portal Cell Other

Yes No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

Yes No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

Yes No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

Please list any physicians you would like copies of office notes and test results sent to.



Signature of Patient or Legal Guardian

Date

**Thank you for choosing Patient Central.
We look forward to caring for you!**

Are You At Risk of **HEART ATTACK?**

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Have you recently experienced any of the following symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain / Pressure / Aching | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Neck or Jaw Tightness | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Racing or Skip Beats | <input type="checkbox"/> Unusual Sweating |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Leg Heaviness or Cramping | <input type="checkbox"/> Leg Swelling |
| <input type="checkbox"/> Persistent Sores on Legs | <input type="checkbox"/> Unusual Fatigue/Weakness |

Do you have any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoking History |
| <input type="checkbox"/> Family History of Heart Disease | <input type="checkbox"/> PAD (Peripheral Arterial Disease) |
| <input type="checkbox"/> Heart Murmur or Heart Valve Problem | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Known Heart Disease | <input type="checkbox"/> Stroke History |

Prevent Heart Disease!
www.samedayheartcare.com



PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL’S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- For all payment plans I have set up, I agree to have my valid credit card information on file to make such payments according to the arranged plan and the policy (See page 2 and 3).

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to **Lansing Cardiovascular Consultants, P.C. (the parent company of Patient Central)** on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

- I hereby authorize Lansing Cardiovascular Consultants, P.C. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

- I request payment of authorized Medicare benefits on my behalf for any services furnished me by or in Lansing Cardiovascular Consultants, P.C. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party

DOB _____

Relationship to Patient



OUR POLICY

Payment Policy

- We require payment of all balances related to your services, including co-pays, deductibles, coinsurance, non-covered service fees, etc. at the time of your visit.
- Cash, personal checks, money orders, debit/credit cards, and HSA cards are accepted.

Payment Plans

- A minimum of 30% must be paid upfront.
- Payment of the remainder of balance must be made within 30 days of the rendered service.
- A valid credit or debit card must be on file with us to ensure your payment.
- In the event of financial hardship, a modified payment plan can be arranged on a case-by-case basis after discussing with our financial counselor.

Billing Statement and Invoices

- We submit claims to your insurance company on your behalf. We also send you an itemized billing statement listing each services and associated charges.
- Upon receipt of payments from your insurance carrier, any services, or portion of services not covered by your insurance plan will be billed to you. This includes unsatisfied deductible and any out-of-pocket expenses not covered by your carrier.
- Full payment is due within 15 days of receipt.
- Your account is considered past due 30 days from the date of the first statement.
- You will receive a maximum of 3 statements (Initial, Past Due, and Final Notice).
- If your account is over 90-day past due and you have not made a payment arrangement, your account may be turned over to a collection agency, including the fees charged by the agency for collection purposes.
- Failure to pay the remaining balances can result in the termination of your care from our practice.



Hospital and Office Procedures

- Prior to the scheduling your procedures, our staff will contact your insurance companies to verify your coverage and to obtain authorization for the procedures.
- When possible, we will verify any coinsurance, unmet deductible amounts, and your unmet out-of-pocket limits. This information will be used to create an **Estimate of Patient Responsibility** based on your insurance benefits. If necessary, our financial counselor will contact you to discuss your financial requirements.
- These are only **Estimates** and can change depending on changes in coverage, unmet deductibles, or if additional procedures need to be performed based on medical necessity.
- Should your payment exceed the cost of service, a refund will be issued to you upon final review and closure of your claim.
- Please note that the authorization received by us from your insurance carrier is NOT a guarantee of payment. **Note: it is your responsibility to understand your coverage and to verify what your insurance plan will pay and if our organization is in the network of your plan. We cannot guarantee that your insurance carrier will pay all or even part of your claim. Please be aware that the balance of your claim is your responsibility. We strongly advise that you work with us during the process of directly speaking with your insurance plan administrator to fully understand all limitations and obligations under your contracted coverage.**

Medical Records and Miscellaneous Services

- The fees for below services will be collected prior to the processing and release of the requested information.
- **Medical Records Requests:** Please allow 5-7 business days to process all requests for medical records. The fee for this service will be \$30 for up to 25 pages; \$10 for a CD.
- **Disability/FMLA Forms:** A fee of \$30 will be charged per injury/episode of care being documented. Please allow 5-7 business days to process.
- **Imaging/X-Ray Requests:** For each CD, there will be \$10 charge.

No Show or Late Cancellation Charge

- For every no-show or late cancellation of an office testing without a minimum of 24-hour advance notice, there will be a \$30 charge. More than 3 no shows and/or late cancellation can result in the termination of your care from our practice.