



**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Home Address \_\_\_\_\_  
E-mail address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please list any allergy information:

\_\_\_\_\_  
\_\_\_\_\_

**PHARMACY INFORMATION**

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

In case of emergency contact \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**PARTY RESPONSIBLE FOR PAYMENT** (If different from patient)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

I authorize any medical treatment or procedures that may be performed by Children's Cardiovascular Medicine & Family Preventive Medicine.

Patient Name (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

**PATIENT CONSENT FOR  
USE AND DISCLOSURE OF PROTECTED HEALTH  
INFORMATION**

With my consent, ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** may use and disclose protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** 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. ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practices may be obtain by forwarding a written request to, ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** Attn: Privacy Officer at 780 Canton Rd., Suite 350, Marietta, Georgia 30060.

With my consent, ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** may call my home or other designated location and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements.

With my consent, ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** may e-mail my appointment reminder cards and patient statements. I have the right to request that ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent ***Children’s Cardiovascular Medicine & Family Preventive Medicine*** may decline to provide treatment to me.

\_\_\_\_\_  
Patient name (Please print)

\_\_\_\_\_  
Print Signature

\_\_\_\_\_  
Today’s date

## **Children’s Cardiovascular Medicine & Family Preventive Medicine Financial Policy**

### **Insurance**

The \$225 is due at time of service. We will bill your insurance as a courtesy. If we were reimburse by your insurance, we would refund the money to you.

\_\_\_\_\_ **Please initial that I have read and agreed to the above statement.**

### **Appointment Cancellations**

Our policy is to charge for missed appointments as this may prevent another patient from their treatment. However, we understand that there are times when you must miss an appointment due to prior obligations or an unseen emergency. We ask that you notify our office within 24 hours of your scheduled appointment so that we may assist you. If you are unable to reach our office during business hours, please leave a message on our voice mail.

\_\_\_\_\_ **Please initial that I have read and agreed to the above statement.**

We realize that temporary financial situations may affect timely payment on your account. We encourage you to contact our billing department within our office and we will gladly work out payment arrangements on your account.

Our practice is committed to providing the best treatment to our patients. Please let us know if you have any questions or concerns.

I authorize Children’s Cardiovascular Medicine & Family Preventive Medicine to release any medical or other information to the insurance carrier, which may be necessary to process the claims. I authorize my insurance company to pay for services provided. I have read and understand the financial policy and its guidelines.

Patient Name (Please Print) \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today’s date: \_\_\_\_\_