Children's Cardiovascular Medicine & Family Preventive Medicine

"Your Health, Your Family's Health, in Your Hands"

ICAEL Accredited Echocardiography Laboratory

PATIENT INFORMATION

Last Name _____ **First Name**_____
Date of Birth _____ **Sex: Male** _____ **Female** _____
Home Address _____
City _____ **State** _____ **Zip Code** _____
Daytime Phone _____ **Cell Phone**: _____

Please list any allergy information: _____
_____

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name _____ **Phone** _____ **Fax** _____

PHARMACY INFORMATION

Pharmacy Name _____ **Phone** _____ **Fax** _____

GUARDIAN INFORMATION (Parents or Legal Guardian)

Last Name _____ **First Name**_____
Date of Birth _____ **Social Security #** _____
Home Address _____
City _____ **State** _____ **Zip Code** _____
Cell Phone _____ **Business Phone**_____
Email Address _____
(Please note that guardianship documentation must be provided at the time of service if your relationship with patient is other than parent)

EMERGENCY CONTACT INFORMATION

In case of emergency contact _____
Phone _____ **Relationship to patient** _____

PARTY RESPONSIBLE FOR PAYMENT (If different from patient's legal guardian)

Relationship to patient: (circle one) Mother Father Legal Guardian Other: _____
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/Guardian Signature _____

Today's Date _____

PATIENT CONSENT FOR
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I give my consent to allow the adults listed below to bring my child to ***Children's Cardiovascular Medicine & Family Preventive Medicine*** for medical treatment.
I <u>authorize</u> the staff of *Children's Cardiovascular Medicine & Family Preventive Medicine* to disclose protected health information at the time of the visit as needed to facilitate the medical care of my child to the adult(s) listed below

Name	Relationship to Child	Phone Number

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 obtained 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.

_____ _____
Signature of Patient Legal Guardian Date

_____ _____
Print Name of Legal Guardian Patient's name

Children's Cardiovascular Medicine & Family Preventive Medicine
Financial Policy

Insurance

We participate with most insurance plans. If you are not insured, payment for services is required in full at each visit. We will submit your claim(s) to your insurance company and assist you in any way we can to expedite the processing of your claim. Please be aware that at times your insurance company may request certain information directly from you in order to process your claim. It is your responsibility to comply with their request. Please notify our office immediately should you have any changes to your insurance information. You may be responsible for the claim(s) should you fail to provide the current insurance information in a timely manner. If your insurance company does not process your claim in 45 days, the balance of the claim(s) will automatically be billed to you.

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

Co-payments and Deductibles

All co-payments and deductibles must be paid at the time of service as part of your contract with your insurance company. Payment in full is required at the time of service for any past due balance on your account. Any check returned for insufficient funds will be subject to a $30.00 service charge. Please be aware that if an unpaid balance remains on your account and is over 90 days past due, we may refer your account to a collection agency.

_____ **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.

_____ _____

Legal Guardian Name (Please Print) Patient Name

_____ _____

Legal Guardian Signature Today's Date