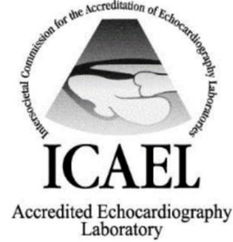

PATIENT INFORMATION

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

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.

Patient Name (Please Print) ____

Patient Signature: ______________________________ Today's date: __________________________