LAS CRUCES CARDIOLOGY

DATE_____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY

PATIENT NUMBER_____

PATIENT INFORMATION

SOCIAL SECURITY#_____

FIRST NAME_____MIDDLE_____

LAST NAME_____

SEX:_____DATE OF BIRTH_____/_____/_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED

RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ ASIAN OTHER

ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO

CHECK BOX ETHNICITY OR RACE IS DECLINED:

☐ EMPLOYED ☐ RETIRED ☐ STUDENT ☐ DISABLED

EMPLOYER_____

REFERRING PROVIDER_____

MAILING ADDRESS:

_____

CITY_____ STATE_____ ZIP_____

EMAIL_____

FIRST CONTACT PHONE (___) _____

WORK PHONE (____)_____

PHARMACY NAME_____

PHARMACY ADDRESS_____

EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT PHONE_____

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARDS TO THE RECEPTIONIST)

INSURANCE COMPANY NAME

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

POLICY#_____GROUP#_____PHONE(_____)_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME_____

INSURANCE/CARD HOLDER'S NAME_____RELATIONSHIP_____

POLICY#_____GROUP#_____PHONE(_____)_____

SPOUSE/ GUARANTOR/ RESPONSIBLE PARTY

RELATIONSHIP_____

FIRST NAME_____

LAST NAME _____

DATE OF BIRTH_____/_____/_____

DAYTIME PHONE (_____)_____

EVENING PHONE (_____)_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly To the physician of the surgical and or medical benefits. if any, otherwise payable to me for his / her services as described, realizing I am responsible to pay non- covered services _____

SIGNATURE OF PATIENT DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

SIGNATURE OF PATIENT DATE

YEARLY UPDATED INFORMATION BY INITIALING AND DATING FOR HIPAA PURPOSE

INITIAS_____ INITIALS_____ INITIALS_____ INITIALS_____

DATE_____ DATE_____ DATE_____ DATE _____

HIPAA
PATIENT ACKNOWLEDGMENT & CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand and consent that this information and will be used to:

- Conduct plans and direct my treatment and follow-up among multiple healthcare providers to include Las Cruces Cardiology with referring providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certificates

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information, I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change it Notice of Privacy Practices above to obtain a current copy of the Notice of Privacy Practice

I understand that I may request in writing that you restrict how my private information is to be used or disclosed to carry out treatment, payment of healthcare operations. I also understand that you are not required to agree to my requested restrictions

I acknowledge that I have read and received a copy of this organization's *Notice of Privacy Practices.*

Patient Name:_____

Signature:_____ Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but were unable to do so for one or more of the following reason:

() Individual refused to sign
() An emergency situation prevented us form obtaining acknowledgment
() Other (Please specify)_____

Financial Responsibility

PLEASE READ EACH ITEM CAREFULLY, INITIAL NEXT TO EACH LINE. SIGN AND DATE AT BOTTOM OF PAGE.

_____ The Patient or his legal representative is ultimately responsible for all charges incurred.

_____ Necessary medical services will be provided regardless of the Patient's ability to pay.

_____ The office will bill insurance claims for the patient as a courtesy, and must approve the assignment of benefits to be paid to the provider of service. However the patient will be responsible for the charges if insurance does not cover any of the services rendered.

_____ Patients with insurance will be responsible for co pays, co-insurance, cost-share and deductibles at the time of service

_____ Patients who are uninsured will be responsible for payment in full at time of service. If a major procedure is scheduled electively you may discuss a payment plan with the billing manager.

_____ Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements are approved by billing manager.

_____ Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if medical attention is not urgent.

_____ The following payment methods will be accepted: cash, check, money orders and credit cards.

_____ Accounts which cannot be collected by the physician after normal in house collections procedures may be referred to a collection agency, magistrate or attorney for further collection action in accordance with the physicians established guidelines

_____ The physician recognizes the need for audits of insurance claims by insurance companies or their contracted audit firms. The physician will cooperate in making available required information provide that 95% or covered charges have been paid prior to the audit. Additional fee may be charged based on the costs incurred in providing the requested information and assistance.

_____ Due to Medicare regulations we are unable to offer any reduced or discounted services.

_____ Overpayments will be refunded to the appropriate party, normally the insurance or guarantor. Patients refund will not be processed until all active pr past due accounts are paid in full. Refunds of less than 5.00 will not be issued unless specifically requested. Within 6-8 weeks.

Patients who do not present updated insurance cards at the time of service will be responsible for the balance in full.

Patient or Guardian Signature_____ Witness Signature_____

Date:_____ Date:_____

LAS CRUCES CARDIOLOGY

Authorization to release medical information to individual/Family Members

In Accordance with Federal government privacy rules implemented through the Healthcare Information Portability Accountability Act of 1996 (HIPAA), in order for your physician or the staff of Las Cruces Cardiology, LLC to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that thes rules may be waived

_____ I do not authorize Las Cruces Cardiology, LLC to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize Las Cruces Cardiology, LLC (verbally) and or (written) to release any or all information concerning my medical care to the following individuals.

Name **Relationship to Patient**

Name **Relationship to Patient**

Name **Relationship to Patient**

Patient Signature **Date**

Witness **Date**

PATIENT MEDICAL HISTORY

TODAYS DATE:_____

NAME: _____ AGE:_____
DATE OF BIRTH_____
REFERRING DOCTOR OR PRIMARY DOCTOR_____
SOCIAL SECURITY NUMBER_____
EMERGENCY CONTACT:
NAME/RELATIONSHIP _____**PHONE** _____

WHEN FILLING OUT THIS FORM PLEASE COMPLETE AS MUCH AS POSSIBLE

WHICH OF THE FOLLOWING BROUGHT YOU TO OUR OFFICE? PLEASE CIRCLE

CHEST PRESSURE, PAIN, OR DISCOMFORT
HEART MURMUR
PALPITATIONS OR IRREGULAR HEARTBEAT
SHORTNESS OF BREATH
DIZZINESS OR PASSING OUT
ABNORMAL EKG
SWELLING IN YOUR FEET AND/OR ANKLES
PAIN IN LEGS WHEN WALKING

OTHER:

HAVE YOU EVER BEEN DX OR TREATED FOR ANY ILLNESS? PLEASE CIRCLE

DIABETES
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
CAROTID STENOSIS
HEART FAILURE
VARICOSE VEINS
PROBLEMS
OTHER, PLEASE LIST
PERIPHERAL VASCULAR DISEASE
PALPITATIONS
ATRIAL FIBRILLATION
HEART ATTACK
STROKE OR TIA
CORONARY DISEASE
SYNCOPE (FAINTING)
COPD, EMPHYSEMA
ASTHMA
PULMONARY EMBOLISM
HEART VALVE

PLEASE LIST ANY SURGERIES/ILLNESSES THAT YOU HAVE BEEN HOSPITALIZED FOR. AND THE APPOXIMATE DATE OF SURGERY/HOSPITALIZATION.

NAME:_____ DOB_____

HAVE YOU EVER SEEN A CARDIOLOGIST BEFORE YES NO
NAME AND LOCATION
HAVE YOU EVER HAD CARDIAC CATHETERIZATION OR ANGIOGRAM?
OPEN HEART SURGERY?

******DO YOU HAVE AN ANY ALLERGIES TO MEDICATIONS ? YES NO**
WHAT MEDICATIONS ARE YOU ALLERGIC TO PLEASE LIST

RISK FACTORS FOR CORONARY ARTERY DISEASE:
FAMILY HISTORY:
HAS MOTHER/FATHER/BROTHER/SISTERS HAD A HEART OF STROKE?
WHO? AT WHAT AGE?

CIGARETTES:
HAVE YOU EVER SMOKED? **YES NO**
HOW MANY CIGARETTES DO YOU SMOKE A DAY?
HOW MANY YEARS HAVE YOU BEEN SMOKING?
WHEN DID YOU QUIT SMOKING? **OR I HAVE NOT**
DO YOU SMOKE A PIPE OR CIGARS? **YES NO**

EXERCISE: DO YOU REGULARLY EXERCISE? **YES NO**
WHAT TYPE OF EXERCISE DO YOU DO?
HOW OFTEN DO YOU EXERCISE?
HOW LONG DO YOU EXERCISE?

SOCIAL HISTORY
CURRENT OCCUPATION OR JOB:
HIGHEST LEVEL OF EDUCATION:
MARITAL STATUS (SINGLE/MARRIED/DIVORCED/WIDOWED/SEPARATED/ENGAGED)
WHO DO YOU LIVE WITH?

DO YOU DRINK ALCOHOLIC BEVERAGES? **YES NO**
WHAT DO YOU USUALLY DRINK?
HOW MANY DRINKS A DAY AVERAGE? HOW MANY BEERS A DAY?
DO YOU USE ANY ILLICIT DRUGS? **YES NO** WHICH ONES?