PATIENT REGISTRATION
Coastal Cardiology, PA

Cardiologist: _____, M.D., F.A.C.C **Primary Physician:** _____

Patient Information

Account #	SS#	Gender:	Age:	DOB:
First Name:	Middle Init:	Last Name:		
Address:		Home Phone: **Check the box of the Primary Phone Number** ☐		
City, State & Zip:		Work Phone: ☐		
Email:		Cell Phone: ☐		
Race/Ethnicity: Black Hispanic White Other:		**Primary Language:**		
Disability Status: Briefly describe disability				

Responsible Party ☐ **SELF** (information same as above)

Relationship to Patient:		Date of Birth:
First Name:	Initial:	Last Name:
Address:		Home Phone:
City, State & Zip:		Cell Phone:
Social Security #:		Work Phone:

Insurance Information

PRIMARY INSURANCE		Subscriber:	DOB:
Address:		Policy ID:	Group:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	
SECONDARY INSURANCE		Subscriber:	DOB:
Address:		Policy ID:	Group #:
City, State & Zip:			
Plan Phone #:		Patient Relationship to Subscriber:	

Parent/Legal Guardian/Spouse & Emergency Contact Information

Parent/Legal Guardian/Spouse Name:	**Emergency Contact:**
Address (if different than patient's):	**Address** (if different than pati ent's):
City, State & Zip:	**City, State & Zip:**
Relationship to Patient:	**Relationship to Patient:**
Home Phone: Other Phone:	**Home Phone:** **Other Phone:**

Medical Authorizations & Release of Information

I hereby authorize Coastal Cardiology, PA to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. I understand that I am financially responsible to said doctors for all charges. I hereby authorize Coastal Cardiology, PA to provide such medical services including surgery. If necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

→ **Signature** _____ **Date** _____

OVER

PATIENT REGISTRATION
Coastal Cardiology, PA

Payment of Services, Insurance Benefits, Authorization to Release/Obtain Information

I hereby authorize Coastal Cardiology, PA to obtain any medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any medical records concerning my care to any physician, hospital or other health care professional providing care to me. Additionally, I authorize the Practice release any medical records concerning my care to my medical insurance company (i.e. Medicare, Medicaid, and insurance company, third party administrator, or managed care company) except as specifically provided below_____

I am aware that the records may contain information relating to psychiatric or psychological testing, physical abuse and/or alcohol abuse and/or HIV test results if any.

I realize that I am responsible for payment of all medical service rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. If I am not eligible or services rendered are not covered benefits under the terms of my employers Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered. **All appointments are confirmed by an automated system and we encourage you to listen to entire message. 24 hour notice of cancellation is required. Failure to provide adequate notice may result in a $50 "no show" fee that must be paid prior to rescheduling.**

_____ _____

→ **Signature** **Date**

By refusing to sign the above, I understand that my insurance company will not be billed by Coastal Cardiology, PA and I am responsible for payment at the time of service.**

_____ _____

Signature **Date**

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with the members of your family or other individuals **(someone other than yourself or your doctors)** 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 these rules may be waived.

I authorize the Practice to release verbally and/or photo copies of any or all medical and billing information, pertaining to my medical care, to the following **family members or individual**; I understand this information may only be released to the individual after proper identification has been presented to the business office. The authorized person may be requested to obtain this information by appearing in person at the business office.

☐ **I do not authorize** the Practice to release any or all information concerning my medical care to any individual except as set forth above.

☐ **I authorize** the Practice to release verbally and/or photocopies of any or all information concerning my medical care (appointments, prescriptions, etc) to the following individuals:

☐ **I authorize the Practice to view my prescription history from external sources** (other doctors, pharmacies, etc).

Print Name	Relationship to Patient	DOB	Phone #	Cell #

→ **Patient Signature** **Date**

Street Address required (if P.O. Box was given on front):

Patient Address:_____ City _____ Zip _____