Patient Registration

AHVC
ADVANCED HEART & VEIN CENTER

Preferred Patient Name: _____ Today's Date: _____

First Name: _____ Last Name: _____ MI _____

Social Security #: Last 4- _____ DOB: _____

E-mail: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

CONTACT PHONE NUMBERS

Primary: ☐ Cell ☐ Home ☐ Work

Cell: _____

Home: _____

Work: _____

EMPLOYER

Working: ☐ Retired ☐ Working ☐ Not Working

Company Name: _____

Position: _____

Preferred Communications: ☐ Text ☐ Phone ☐ E-mail

Pharmacy: _____ City: _____ Cross Streets: _____

Primary Care Physician: _____ Office/Group: _____

Referring Physician (if diff than PCP): _____

ADDITIONAL INFORMATION

Preferred Language: _____ Translator Needed: ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino Marital Status: ☐ S ☐ M ☐ W ☐ D

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other Race Sex: ☐ M ☐ F

Emergency Contact: _____ Phone: _____ Relation: _____

Insurance Coverage

AHVC
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☐ SELF PAY

☐ PRIMARY INSURANCE PLAN:

_____

Are you the Policy Holder? ☐ Yes ☐ No Copy of Card Provided? ☐ Yes ☐ No

If not, Policy Holder Name: _____ Relationship to you: _____

Insurance ID Number: _____ Group Number: _____

☐ SECONDARY INSURANCE PLAN:

_____

Are you the Policy Holder? ☐ Yes ☐ No Copy of Card Provided? ☐ Yes ☐ No

If not, Policy Holder Name: _____ Relationship to you: _____

Insurance ID Number: _____ Group Number: _____

INSURANCE AUTHORIZATION & ASSIGNMENT, & PAYMENT RESPONSIBILITY

I HEREBY AUTHORIZE ADVANCED HEART AND VEIN CENTER TO FURNISH INFORMATION TO ANY AND ALL INSURANCE CARRIERS CONCERNING MY MEDICAL RECORDS AND TREATMENTS. I AUTHORIZE ADVANCED HEART AND VEIN CENTER TO APPEAL ANY UNPAID INSURANCE CLAIMS ON MY BEHALF. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND ALL THE CHARGES INCURRED FROM THOSE SERVICES. ALTHOUGH I HAVE REQUESTED THE PRACTITIONER TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE FOR ANY REASON. I WILL ALSO BE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE AMOUNTS, AND DEDUCTIBLES. ANY PAYMENTS MADE DIRECTLY TO THE PATIENT AND OWING TO THE PHYSICIANS WILL BE REMITTED IMMEDIATELY, PAYABLE TO ADVANCED HEART AND VEIN CENTER, INC. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. I AM RESPONSIBLE FOR FURNISHING ALL THE INFORMATION REQUESTED ABOVE, AND ALSO RESPONSIBLE FOR FURNISHING ANY NECESSARY INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION OR OFFICE SURGICAL PROCEDURES. IF THERE IS A DEFAULT IN ANY ONE PAYMENT (NO PAYMENT WHEN DUE) THERE WILL BE AN ADDED 30% COLLECTION OR REASONABLE ATTORNEYS' FEE, PLUS ALL COSTS, IF MY ACCOUNT GOES TO A COLLECTION AGENCY OR COLLECTION ATTORNEY FOR COLLECTION OR LITIGATION.

Please provide a minimum of 24 hours advance notice, if you must cancel an appointment.

Signature of Patient/Authorized Person: _____ Date: _____

TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) , _____ agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care.

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers

DECLINE _____ (Initials of Patient)

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes. DECLINE (initials of patient)

DECLINE _____ (Initials of Patient)

Signature of Patient/Authorized Person: _____ Date: _____

Patient Name (Please print) _____

MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY

☐ I have chosen not to participate further in this telemedicine evaluation

Signature of Patient/Authorized Person: _____ Date: _____

Signature of Witness: _____ Date: _____

Notice of Privacy Practices

AHVC
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing, I acknowledge that I received the Notice of Privacy Practices. I understand that I may contact the person named in the Notice, if I have any questions about the content of the Notice:

Patient Name (PRINT)	Patient Date of Birth
Signature of Patient or Legally Responsible Person	Date

*If signature not obtained, staff to complete back of form

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

PROVIDE INFORMATION FOR ANY PERSONS WITH WHOM WE MAY DISCUSS YOUR CARE AND PROVIDE TEST RESULTS, INCLUDING SPOUSE OR CHILD.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

INDICATE ALL METHODS VIA WHICH YOU WOULD LIKE TO RECEIVE CONFIDENTIAL INFORMATION:

Home Voicemail? ☐ Yes ☐ No

Cell Voicemail? ☐ Yes ☐ No

Other Voicemail? ☐ Yes ☐ No

E-Mail? ☐ Yes ☐ No

I'm aware that this consent will remain in effect until such time that I provide written notification to end this agreement. I'm aware that no other person than those listed above, will be allowed to discuss my care, be given financial information, or be allowed to make or cancel appointments on my behalf.

Patient Signature: _____ Date: _____