HEART& VASCULAR CLINIC

620 Stanton Christiana Rd
Suite 203
Newark, DE 19713
Phone: (302) 338-9444
Fax: (302) 994-9449

212 Carter Drive
Suite D
Middletown, DE 19709
Phone: (302) 261-8200
Fax: (302) 994-9449

410 Foulk Road
Suite 101
Wilmington, DE 19803
Phone: (302) 518-6200
Fax: (302) 994-9449

PATIENT REGISTRATION FORM

Date: _____

Patient Last Name: _____ **First:** _____ **Middle Initial:** __
Mr. □ Mrs.□ Miss □ Ms □

Social Security Number: _____ (Complete Social Security number is required.)

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Date of Birth: ____/____/____ **Age:** ___ **Sex:** □ Male □ Female

Home Phone: _____ **Cell Phone:** _____

Address: _____ **P.O. Box** _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Email Address: _____

Occupation: _____

Employer: _____

Employer's Phone Number: _____

Employer's Address: _____

City: _____ **State:** _____ Zip **Code:** _____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name: _____

Physician Phone: _____

Physician Street Address: _____

City: _____ State: _____ Zip Code: _____

PHARMACY INFORMATION

Pharmacy: _____ Pharmacy Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient: _____ Phone Number: _____

Email: _____

Name: _____

Relationship to patient: _____ Phone Number: _____

Email: _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____

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INSURANCE INFORMATION

Primary Insurance Provider: _____

Policy Number _____ **Group Number** _____

Policy Holder Name: _____

Subscriber's S.S. No. : _____ **Subscriber's D.O.B:** _____

Patient Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Secondary Insurance Provider (if applicable): _____

Policy Number _____ **Group Number** _____

Policy Holder Name: _____

Subscriber's S.S. No. : _____ **Subscriber's D.O.B**: _____

Patient Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Tertiary Insurance Provider (if applicable): _____

Policy Number _____ **Group Number** _____

Policy Holder Name: _____

Subscriber's S.S. No. : _____ **Subscriber's D.O.B**: _____

Patient Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

AUTHORIZATIONS AND ACKNOWLEDGEMENTS:

- The above information is true to the best of my knowledge.

- I hereby authorize payment directly to the Heart and Vascular Clinic, P.A. for all benefits payable to me under the terms of insurance policy for treatment of services provided to my dependents or me.

- I authorize the release of any medical information necessary to process such insurance claims.

- I understand that I am financially responsible for any balances or charges not covered by my insurance(s).

- I hereby authorize release of any medical information from hospitals, labs, or other physician's offices to aid in my care.

_____ _____

Patient/Guardian Signature *Date*

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HIPAA Compliance Patient Consent Form

- Our Notice of Privacy provides information about how we may use or disclose protected health information.
- The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
- The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
- You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
- By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Would you like us to contact you via phone, email, or text message to confirm your appointments?
☐ Yes ☐ No

Are we permitted to leave a message on your home or cell phone answering machine?
☐ Yes ☐ No

Do you authorize us to discuss your medical conditions with any family members?
☐ Yes ☐ No

If yes, please list the family members: _____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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FINANCIAL POLICY

Dear Patient,

1.) It is our office policy that all co-pays, co-insurance and deductible charges are paid prior to services being rendered. In the event that you are scheduled for a surgery, payment is due no later than 24 hours before you are scheduled to report to the hospital or office.

2.) All past due balances are expected to be paid before further services are rendered at Heart and Vascular Clinic. If you have financial difficulties and cannot pay your past due balance, payment arrangements may be made by credit card, which will be kept on file and charged at intervals agreed upon by the billing department and the patient or guarantor.

3.) If we do not accept your insurance as in-network, you will be responsible for the full cost of the services rendered. We will bill your insurance company for you and will issue you a refund if we receive payment. In the instance that your insurance should fail to pay for your visit, you agree to remain the responsible party and your payment will not be refunded.

4.) ALL REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT & MUST BE PRESENTED AT THE TIME OF VISIT. In the event that you fail to get a referral and one is required, you will be asked to sign a waiver and pay in full or you may reschedule your appointment.

5.) I understand that knowing the terms, limitations and guidelines of my health insurance policy is my responsibility as a patient and I assume all financial responsibility for any charges incurred as a result of policy termination or coordination of benefits or limitation otherwise not mentioned that results in non-payment.

Please contact the billing department with any questions at (302) 338-9444

Thank you for your cooperation. We look forward to seeing you.

I, the undersigned, acknowledge, understand and agree to the contents of this notice.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____