Southeast Cardiovascular Associates

Board Certified, Interventional Cardiology, Cardiovascular Disease & Nuclear Cardiology

Rajan Kadakia MD Nisheeth Goel, MD Manu Pillai MD Marlos Fernandes MD Arvin Bansal MD

Patient Registration - WELCOME TO OUR OFFICE

Patient Name: ____ Date of Birth:______________

Home Address: ____ Apt / Unit: ______________

City: _________________________ State:______ Zip: __________ SSN:___________________________

Telephone: Home: ____________________ Cell: __________________ Work: __________________

Email: ____

Marital Status: ______________________ Name of Spouse / Partner: ______________________________

Preferred method of contact: □ Home □ Cell □ Work □ E-mail

May we leave messages about appointments and results? □ YES □ NO

Race: □ ASIAN □ BLACK OR AFRICAN AMERICAN □ CAUCASIAN/WHITE □ HISPANIC □ NATIVE AMERICAN

□ OTHER: (Please specify) ____

Ethnicity: ____

Language: ____________Do you need an interpreter? □ YES □ NO If yes, what type of interpreter? ____________

Employer: ____ Occupation: ___________________________

Employer's Address: ______________________________ City: ____________ State: _____ Zip: _________

Primary Care Physician: ____

Referring Physician / Person (if not PCP): ____

Emergency Contact: **(not living at same address)**

Name: ____ Relationship: ____________________

Phone Number(s): ______________________________ or: ____

Do you have a Health Care Power of Attorney? □ YES □ NO (If yes, please provide a copy of the POA documents)

Name: ____ Phone #: ______________________________

Release of Information:

Name: ____ Relationship: ____________________

Phone Number(s): ______________________________ or: ____

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Patient Name: ____ Date of Birth:______________

Symptom(s) or reason for office visit: ____

Allergies: ____ Allergy to Iodine? □ YES □ NO

Pharmacy Name: _______________________________________ Pharmacy Phone #: ______________________

Do you smoke or use tobacco products: □ YES □ NO If yes, what type?: ___________________________________

How many cigarettes do you smoke per day?: ____________ How long have you smoked?: ____________________

Past Medical History: (Note: If yes, please check)

High Blood Pressure:_____________________________ Diabetes: ___________________________________

High Cholesterol: _______________________________ Arrhythmia: _________________________________

Congestive Heart Failure: _________________________ Palpitations: ________________________________

Carotid or Peripheral Vascular Disease: ____

Other (please specify): ____

Past Surgical History: (Note: If yes, please check and provide YEAR)

Angiogram: ___________________________________ Bypass Surgery: ______________________________

Heart Stent: ___________________________________ Leg Stent: ___________________________________

Pacemaker / ICD: _______________________________ Valve Replacement: ____________________________

Other (please specify) :____

Please list all your prescription medication(s): **List Name, Dosage, and Frequency**

1. ____ 7. ____
2. ____ 8. ____
3. ____ 9. ____
4. ____ 10. ____
5. ____ 11. ____
6. ____ 12. ____

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Primary Insurance

Name of Insurance: ______________________________
Policy #: ______________________________ Group #: ______________________________
Claims Mailing Address: ______________________________
City: ______________ State: _______ Zip Code: __________ Phone: ______________

Insured/Responsible party if other than patient

Insured's Name: ______________________________ DOB: ______________ Phone: ______________
Insured's SSN #: ______________________________ Insured's Employer: ______________________________

Secondary Insurance

Name of Insurance: ______________________________
Policy #: ______________________________ Group #: ______________________________
Claims Mailing Address: ______________________________
City: ______________ State: _______ Zip Code: __________ Phone: ______________

Insured/Responsible party if other than patient

Insured's Name: ______________________________ DOB: ______________ Phone: ______________
Insured's SSN #: ______________________________ Insured's Employer: ______________________________

Insurance

We make every effort to contact your insurance company and verify your benefits. However, verification of insurance benefits is not a guarantee of payment until claims are submitted and the insurance company reviews all records. **If your insurance denies payment or services are not covered, you will become financially responsible for services.**

Please be aware that if you participate in an HMO and need a referral for this visit or any other services, **it is your responsibility to make sure we have the referral in our office before the visit. The office cannot be responsible for obtaining the referral.**

Assignment of Benefits and Release of Information

I hereby assign and convey directly to Southeast Cardiovascular Associates as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Southeast Cardiovascular Associates to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Southeast Cardiovascular Associates any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Southeast Cardiovascular Associates or its attorneys in order to claim such medical benefits.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERSA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Self-Pay

If you do not have insurance, or if we cannot verify your coverage, payment is due at time of service.

Signature: ______________________________ Date: ______________________________

Patient Name: ______________________________ Date of Birth: ______________________________

Person other than patient: ______________________________ Relationship: ______________________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain Payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

I HAVE RECEIVED A COPY OF THE PRIVACY POLICY OF ***SOUTHEAST CARDIOVASCULAR ASSOCIATES*** AND I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL FACILITY, OR IT'S REPRESENTATIVE, TO RELEASE ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTION, OR TREATMENT AND COPIES OF ALL MEDICAL RECORDS TO ***SOUTHEAST CARDIOVASCULAR ASSOCIATES***.

A COPY OF THE PRIVACY POLICY IS AVAILABLE TO YOU ON OUR WEBSITE AT www.southeastcardio.com.

Signature: ____ Date: __________________________________

Patient Name: ____ Date of Birth: __________________________

Person other than patient: ______________________________ Relationship: ___________________________

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NO SHOW POLICY

A "no show" is when a patient fails to keep a scheduled appointment.

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A no show may generate a **$25.00** fee per incident.

In the event that you have a special circumstance regarding your missed appointment, please contact our office. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

ADMINISTRATIVE PAPERWORK AND LETTER FEE

Southeast Cardiovascular Associates will charge a $30.00 administrative fee for any forms, paperwork or letters that we are asked to complete or write for you or your family members. The fee is payable at the time the forms are submitted for completion. Forms requiring the fee would include, but not be limited to FMLA paperwork, supplemental insurance policy claim forms, detailed release to work forms, medication assistance forms, transportation assistance forms, disabled parking requests, or debt forgiveness forms.

The patient or family member should fill out their portion of the form themselves as completely as possible prior to submitting to our office. **Please allow 7-10 business days for all forms to be completed.** Completed forms can be picked up from the front desk or can be faxed, if requested.

MEDICAL RECORDS

Southeast Cardiovascular Associates will provide your records to you once you have completed the appropriate medical records request form. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form, unsigned requests cannot be processed and we will either mail or fax the records to you.

Fee for records will be $30.00. **Your request will be processed and fulfilled within 15 business days.**

RETURNED CHECKS NSF

There is a $35.00 charge for any returned checks in addition to the insufficient funds amount.

Signature: ____ Date: _________________________________

Patient Name: ____ Date of Birth: __________________________

Person other than patient: _____________________________ Relationship: ___________________________