Premier
PEDIATRIC CARDIOLOGY

PATIENT REGISTRATION FORM

Today's Date:		Primary or Referring Doctor:	
PATIENT AND FAMILY INFORMATION			
Last Name		First	Middle
DOB	Age	SSN	Sex
Address			
Email		Home Phone:	
Mother's Name		Cell Phone:	
Father's Name		Cell Phone:	
INSURANCE INFORMATION			
Primary Insurance Plan:	ID#:	Group #:	Referrals Needed?
Subscriber's Name:	DOB:	Relationship to Pt	Copay?
PHARMACY INFORMATION			
Local Pharmacy:	Address:		Tel #
Mail Order Pharmacy:			
IN CASE OF EMERGENCY			
Friend or relative:		Home Phone:	
Relationship to patient:		Cell Phone:	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Premier Pediatric Cardiology, LLC or insurance company to release any information required to process my claims.

_____	_____
Patient/Guardian Signature	Date

Assignment of Benefits and Payment Agreement and Authorization to Release Information

Patient Name _____ Date of Birth_____

I hereby authorize Premier Pediatric Cardiology, LLC (PPC) to furnish to my insurance carrier(s), attorney, or legal representative all information which said parties may request concerning my illness or injury. I hereby assign to PPC all benefits payable by my insurance company and/or third party payor for services received by me until the amounts owed, including interest and attorney fees, are paid in full. I further agree and accept as follows:

My insurance policy is a contract between me and my insurance carrier. In such event where any laws or regulations supersede this Assignment of Benefits, I recognize that I am personally responsible to PPC for ALL charges for services rendered plus interest that will accrue on the outstanding balance at the rate of 1 percent per month (12 % per annum).

I recognize that PPC will bill and collect from my insurance carrier as a courtesy to me. I will be informed as to any balance due from me to PPC. I fully understand that PPC may not accept the amount an insurance carrier states as their "Usual & customary fees" (UCR) as payment in full when the insurance carrier does not have a current, valid contract with PPC, unless superseded by law or regulation. This may lead to my getting a bill for deductibles, co-payments, and coinsurance. Regardless of my insurance, I will probably have a balance due for services rendered. I agree to pay for any such balance. For those policies that require pre-authorization or referrals, this must be completed prior to seeing any physician. It is my responsibility to obtain all necessary referrals from other physicians, as required by my insurance carrier. I am responsible for understanding my individual insurance policy and benefits prior to seeking services. I will ask for help if my insurance is not clear to me.

Although I may be represented by an attorney on matters related to the illness or injury for which PPC has rendered services to me, I must still keep my account paid in full.

If my account becomes delinquent and is referred to an attorney or agency for collection, I agree to pay 33 1/3 percent of attorney fees and all court costs incurred by PPC, in addition to the outstanding balance of the account.

I fully understand that while PPC is willing to send an insurance claim to my insurance carrier, this is done as a courtesy, and PPC will not be responsible for lost claims or claims that do not arrive at my insurance carrier. Patients are encouraged to remain in touch with their insurance carrier as to the status of the claim. I understand that if payment from my insurance carrier is not received by PPC within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collections.

Patient account balances will be reviewed 90 days after full insurance processing for collections. Patient may receive up to 3 billing statements within the 90 day period after insurance processing and prior to any practice review for collections.

For all office visits co-payments will be collected at the time of service or the appointment will be rescheduled. For patients with high deductible health plans, defined as any plan with a deductible over $1,000, PPC will collect $100 at time of service.

This agreement is in addition to any other agreement which I may have with PPC. I have read this document, understand it fully, and agree to the terms and conditions.

_____

Signature Date

Written Acknowledgement Form

Patient Name _____Date of Birth_____

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____ _____

Signature Date

I understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.

Please allow the following people to have access to my Medical Records (e.g., list name of spouse, parents, children, etc.):

_____

_____

_____

PPC staff has my permission to leave medical information on my home answering machine and/or cell phone voice-mail.

_____

Phone number

_____

Second phone number

_____

Email Address

_____

Patient Signature Date

_____

Patient/Parent Signature

_____

Date

_____

Authorized representative of patient

_____

Relationship to Patient

_____

Date

Premier PEDIATRIC CARDIOLOGY

Patient Name:_____

DOB: _____ **Appt Date:**_____

PATIENT	PHYSICIAN
Why are you or your child here for a cardiology visit:? _____ _____ **I would like today's information sent to:** ❒ **My Doctor** **And also:** _____ **Check any known heart problems:** ❒ heart murmur ❒ chest pain ❒ fainting or dizzy spells ❒ palpitations/irregular heart beat ❒ abnormal EKG ❒ blue spells ❒ high blood pressure ❒ high blood lipids ❒ shortness of breath ❒ swollen legs or eyes **Has the patient ever had:** ❒ evaluation by a cardiologist ❒ EKG ❒ chest xray ❒ holter monitor ❒ echocardiogram ❒ stress test ❒ cardiac catheterization ❒ electrophysiology study/ablation ❒ surgery on the heart or blood vessels ❒ pacemaker/ICD implant **Does the patient have other health problems?** **YES NO** ❒ ❒ Chronic fever, weight problem, headaches ❒ ❒ Eyes ❒ ❒ Ears, Nose, mouth, throat, hearing ❒ ❒ Respiratory, breathing, cough ❒ ❒ Stomach, bowels, vomiting, abdominal pain ❒ ❒ Kidney, bladder, urinary or menstrual ❒ ❒ Muscles, bones, spine, joints ❒ ❒ Skin or rash problems ❒ ❒ Seizures, paralysis, delayed development ❒ ❒ Attention deficit disorder, depression, autism ❒ ❒ Diabetes, thyroid, abnormal growth ❒ ❒ Anemia, sickle cell, abnormal bleeding ❒ ❒ Cancer or leukemia ❒ ❒ Allergies or abnormal immunity ❒ ❒ Change in activity level ❒ ❒ Change in your family or home routine	**CC:** **HPI:** **ROS:**

Premier PEDIATRIC CARDIOLOGY

Patient Name:_____

DOB: _____ **Appt Date:**_____

PATIENT	PHYSICIAN
Is there a family history of heart problems? ❒ **Heart attack or stroke (under the age of 60 years)** ❒ **Sudden death (under 50 years)** ❒ **High blood pressure** ❒ **High cholesterol or triglycerides** ❒ **Heart muscle or valve problems** ❒ **Irregular heart beats** ❒ **Congenital heart problems** ❒ **Seizures or passing out** **Past hospitalizations:** ❒ **No** ❒ **Yes** _____ _____ **Past surgeries:** ❒ **No** ❒ **Yes** _____ _____ **Any problems managing your child's healthcare needs?** ❒ **No** ❒ **Yes** _____ **Patient lives with:**_____ **School grade:** _____ **Activities:** _____ _____ **Employment?** _____	**Family History:** _____ **Past Medical History:** _____ **Social History:**
MEDICATIONS: _____ _____ _____ **ALLERGIES:** _____ _____	Birth Control? _____ Substance Use ❒ **Not applicable (infant or child)** ❒ **YES** ❒ **NO** Flu Shot ❒ **YES DATE:** _____ ❒ **NO** ❒ **OTHER REASON:** _____

VITAL SIGNS:

Heart Rate: _____ BP (Right Arm): _____ BP (Left Arm): _____

Respiratory Rate: _____ BP (Right Leg): _____ BP (Left Leg): _____

Pulse Ox: _____ Height: _____ Weight: _____