Lansing Cardiovascular Consultants, P.C.

Same Day HeartCare™
YOUR CARDIOLOGY CLINIC ON DEMAND

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME______________________ FIRST NAME______________ MIDDLE INITIAL _______

DATE OF BIRTH _______________ SEX ❑ M ❑ F SOCIAL SECURITY ___________________

MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ Other__________ SPOUSE NAME __________________

ADDRESS ____________________ CITY______________ STATE_______ ZIP __________

HOME PHONE ______________ CELL ______________ EMAIL ADDRESS ___________________

PRIMARY CARE PROVIDER ____

RACE ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Hispanic ❑ Other

ETHNICITY ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unreported/Refused

LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Arabic ❑ Chinese ❑ Sign Language

EMPLOYER ______________________________ WORK PHONE ___________________

Responsible Party Information *(for patients under 18 and other dependent patients)*

Name:______________________________ Relationship to patient:______________
Last First Middle Initial

Social Sec. #:

Address:____________________ City:______________ State:________ Zip:__________

DOB:______________ **Sex:** ❑F ❑M Phone:____________________ ❑Home ❑Cell ❑Other
MM/DD/YYYY

Emergency Contact

Name:__________________ Phone:______________ Relationship to patient:______________

Patient's Insurance Information

Primary Policy:____________________	Secondary Policy:____________________
Policy Holder:____________________	Policy Holder: ____________________
Date of Birth:____________________	Date of Birth: ____________________
Relationship to Patient:______________	Relationship to Patient: ______________

Lansing Cardiovascular Consultants, P.C.

Same Day HeartCare™ YOUR CARDIOLOGY CLINIC ON DEMAND

Patient Registration Form (Continued)

Assignment of Benefits

I authorize Patient Central via Lansing Cardiovascular Consultants, P.C. to release such information from my patient records as is required in order to receive reimbursement for any billings rendered relating to my treatment. I request that payment be made either to me or to Lansing Cardiovascular Consultants, P.C. for medical services provided to me. In making this authorization I understand and agree to pay any unpaid balance to include deductible and coinsurance if applicable.

Signature of Patient or Legal Guardian ______________________ Date ______________

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.

Signature of Patient or Legal Guardian ______________________ Date ______________

*****For Medicare Patients Only*****

I request that payment of authorized Medicare benefits be made on my behalf to Lansing Cardiovascular Consultants, P.C. and/or Patient Central for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Patient's MEDICARE Number (HIC) ______________________

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.

Signature of Patient or Legal Guardian ______________________ Date ______________

CARDIOVASCULAR AND MEDICAL HEALTH REVIEW

NAME ______________________ DATE __________ WEIGHT ________ HEIGHT ________ DATE OF BIRTH ____/____/____

PERSONAL HISTORY
PLEASE CIRCLE

SINGLE MARRIED PARTNER DIVORCED WIDOWED

SMOKER FORMER SMOKER NEVER SMOKED

SMOKELESS TOBACCO USER E-CIGARETTE

ALCOHOL USE: DAILY OCCASIONAL RARE NEVER

EMPLOYED UNEMPLOYED DISABLED RETIRED

PAST HEART HISTORY

HAVE YOU HAD?	YES	NO	YEAR
Heart attack	❑	❑	________
Balloon angioplasty	❑	❑	________
Heart stents	❑	❑	________
Heart bypass	❑	❑	________
Leg stents or bypass	❑	❑	________
Carotid stents or surgery	❑	❑	________
Renal/digestive artery stent	❑	❑	________
Vein stripping or ablation	❑	❑	________
Pacemaker implanted	❑	❑	________
ICD implanted	❑	❑	________

Other cardiovascular event/procedure ______________________

____

Do you see other doctors for heart or circulation issues?

____

SYMPTOMS AND RISK FACTORS

DO YOU HAVE OR HAD RECENTLY:	Y	N	WHEN
Chest pain	❑	❑	________
Shortness of breath	❑	❑	________
Angina	❑	❑	________
Palpitations or racing heart	❑	❑	________
Atrial fibrillation	❑	❑	________
Bleeding or clotting disorder	❑	❑	________
Fainting or blackouts	❑	❑	________
Leg pain while walking	❑	❑	________
Varicose veins	❑	❑	________
Leg swelling, heaviness or fatigue	❑	❑	________
Leg itching, burning or throbbing	❑	❑	________
Leg cramps, swelling or restlessness	❑	❑	________
Blood clots in the legs or lungs	❑	❑	________
Do problems with your legs interfere with your lifestyle or limit your activities?	❑	❑	________
Have you had a stroke or mini stroke	❑	❑	________
Sudden visual changes	❑	❑	________
Black areas in your vision	❑	❑	________
Numbness	❑	❑	________
Stumbling or loss of balance	❑	❑	________
Abdominal aortic aneurysm	❑	❑	________
Family history of aortic aneurysm	❑	❑	________
Have you had a screening test for aortic aneurysm			Y N
Have you had a screening test for carotid blockage			Y N
Smoking or history of smoking	❑	❑	
High cholesterol	❑	❑	
High Blood pressure	❑	❑	
Diabetes	❑	❑	
Family history of heart disease or stroke	❑	❑	

OTHER MEDICAL CONDITIONS

DO YOU HAVE?	Y	N	DETAILS
Thyroid disease	❑	❑	________
Lung disease	❑	❑	________
Stomach/digestive	❑	❑	________
Liver problem	❑	❑	________
Kidney problem	❑	❑	________
Brain/neurological	❑	❑	________
Muscle disease	❑	❑	________
Cancer	❑	❑	________

OTHER MEDICAL CONDITIONS?

____

____

____

SURGERY

SURGERY	DATE

ALLERGIES

ALLERGY	REACTION

MEDICATIONS

MEDICATION	DOSE	FREQUENCY

Lansing Cardiovascular Consultants, P.C.

Same Day HeartCare™ YOUR CARDIOLOGY CLINIC ON DEMAND

Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

❑ Yes ❑ No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

____

❑ Yes ❑ No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?
❑ Email ❑ Cell ❑ Text ❑ Other

____

❑ Yes ❑ No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

❑ Yes ❑ No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

____

❑ Yes ❑ No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

____

____

____

Please list any physicians you would like copies of office notes and test results sent to.

____

____

____

____

______________________________ Signature of Patient or Legal Guardian

______________________________ Date

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that **I am financially responsible for my health insurance deductible, coinsurance or non-covered service.**
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
   - For all payment plans I have set up, I agree to have my valid credit card information on file to make such payments according to the arranged plan and the policy (See page 2 and 3).

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   - I hereby authorize and direct payment of my medical benefits to **Lansing Cardiovascular Consultants, P.C. (the parent company of Patient Central)** on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   - I hereby authorize Lansing Cardiovascular Consultants, P.C. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**
   - I request payment of authorized Medicare benefits on my behalf for any services furnished me by or in Lansing Cardiovascular Consultants, P.C. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

____   ___________________

Signature of Patient, Authorized Representative or Responsible Party   Date

____ DOB ____________   ___________________

Print Name of Patient, Authorized Representative or Responsible Party   Relationship to Patient

OUR POLICY

Payment Policy

- We require payment of all balances related to your services, including co-pays, deductibles, coinsurance, non-covered service fees, etc. at the time of your visit.
- Cash, personal checks, money orders, debit/credit cards, and HSA cards are accepted.

Payment Plans

- A **minimum of 30%** must be paid upfront.
- Payment of the remainder of balance must be made within 30 days of the rendered service.
- A valid credit or debit card must be on file with us to ensure your payment.
- In the event of financial hardship, a modified payment plan can be arranged on a case-by-case basis after discussing with our financial counselor.

Billing Statement and Invoices

- We submit claims to your insurance company on your behalf. We also send you an itemized billing statement listing each services and associated charges.
- Upon receipt of payments from your insurance carrier, any services, or portion of services not covered by your insurance plan will be billed to you. This includes unsatisfied deductible and any out-of-pocket expenses not covered by your carrier.
- Full payment is due within 15 days of receipt.
- Your account is considered past due 30 days from the date of the first statement.
- You will receive a maximum of 3 statements (Initial, Past Due, and Final Notice).
- If your account is over 90-day past due and you have not made a payment arrangement, your account may be turned over to a collection agency, including the fees charged by the agency for collection purposes.
- Failure to pay the remaining balances can result in the termination of your care from our practice.

Hospital and Office Procedures

- Prior to the scheduling your procedures, our staff will contact your insurance companies to verify your coverage and to obtain authorization for the procedures.
- When possible, we will verify any coinsurance, unmet deductible amounts, and your unmet out-of-pocket limits. This information will be used to create an **Estimate of Patient Responsibility** based on your insurance benefits. If necessary, our financial counselor will contact you to discuss your financial requirements.
- These are only **Estimates** and can change depending on changes in coverage, unmet deductibles, or if additional procedures need to be performed based on medical necessity.
- Should your payment exceed the cost of service, a refund will be issued to you upon final review and closure of your claim.
- Please note that the authorization received by us from your insurance carrier is NOT a guarantee of payment. ***Note**: it is your responsibility to understand your coverage and to verify what your insurance plan will pay and if our organization is in the network of your plan. We cannot guarantee that your insurance carrier will pay all or even part of your claim. Please be aware that the balance of your claim is your responsibility. We strongly advise that you work with us during the process of directly speaking with your insurance plan administrator to fully understand all limitations and obligations under your contracted coverage.*

Medical Records and Miscellaneous Services

- The fees for below services will be collected prior to the processing and release of the requested information.
- **Medical Records Requests:** Please allow 5-7 business days to process all requests for medical records. The fee for this service will be **$35 for up to 25 pages**; **$15 for a CD.**
- **Disability/FMLA Forms:** A fee of **$35** will be charged per injury/episode of care being documented. Please allow 5-7 business days to process.
- **Imaging/X-Ray Requests:** For each CD, there will be **$15** charge.

No Show or Late Cancellation Charge

- For every no-show or late cancellation of an office testing or visit without a minimum of 24-hour advance notice, there will be a **$40 charge**. More than 3 no shows and/or late cancellation can result in the termination of your care from our practice.