Patient Central
Urgent Care • Primary Care • Heart Care

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME_____ FIRST NAME_____ INITIAL _____

DATE OF BIRTH _____ SEX ❑ M ❑ F SOCIAL SECURITY _____

MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ Other_____

ADDRESS _____ CITY_____ STATE_____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

SPOUSE NAME _____

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:_____

Policy Holder:_____

Date of Birth:_____

Relationship to Patient:_____

Secondary Policy:_____

Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

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Patient Registration Form (Continued)

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Patient Central. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services or vaccinations. Charges for paperwork are not covered by insurance, and will be charged a $30 fee. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**

➡ _____ _____

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

Notice of Narcotic Policy

I understand that Patient Central does not prescribe narcotic medications. In the event I should need this type of medication, I understand I will be referred to a specialist or pain management clinic. Patient Central does not prescribe long term pain medications. I fully accept and will comply with this policy of Patient Central.

➡ _____ _____

Signature of Patient or Legal Guardian | Date

Missed Appointments / *Same Day Cancellation Policy*

I also acknowledge I am responsible for payment of the fees listed below relating to missed appointments and same-day cancellations.
1st – No Charge
2nd - $25
3rd - $100, also may be subject to immediate discharge from our office.

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

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Urgent Care

Patient Name: _____ DOB: _____ Date: _____
MM/DD/YYYY

Reason for being seen today: _____

Have you had any recent international travel? ❑ Yes ❑ No

Is this a follow up visit? ❑ Yes ❑ No

Do you need medication refills? ❑ Yes ❑ No

Allergies:

Are you allergic to any medications? ❑ Yes ❑ No
If Yes, please list all.

Do you have any other allergies? ❑ Yes ❑ No
If Yes, please list all.

Medications:

Are you taking any medications, prescription or over the counter, right now? ❑ Yes ❑ No
If Yes, please list all medications.

Medication Name	Strength	Quantity taken at one time	Times per day taken

Please list any other medications on the back of this form.

Social History:

Do you use tobacco?	❑ Yes, everyday	❑ Yes, on occasion	❑ No, former user	❑ No, never
Do you drink alcohol?	❑ Yes, everyday	❑ Yes, socially	❑ No, former user	❑ No, never
Do you use illegal drugs?	❑ Yes, everyday	❑ Yes, socially	❑ No, former user	❑ No, never
Are you currently employed?	❑ Yes, full time	❑ Yes, part time	❑ No, retired	❑ No, other

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MM/DD/YYYY

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Are you currently employed?	❑ Yes, full time	❑ Yes, part time	❑ No, retired	❑ No, other

Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

Condition	Yes	No	Relative	Condition	Yes	No	Relative
Diabetes				Osteoarthritis			
High Blood Pressure				Rheumatoid Arthritis			
Heart Disease				Heart Attack/ Murmurs			
Cancer				Thyroid Disease			
Type				High Cholesterol			
Kidney Disease				Liver Disease			
Dementia				Stroke			

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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?
❑ Portal ❑ Cell ❑ 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

Thank you for choosing Patient Central.
We look forward to caring for you!

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Are You At Risk of HEART ATTACK?

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Have you recently experienced any of the following symptoms?

- ❑ Chest Pain / Pressure / Aching
- ❑ Neck or Jaw Tightness
- ❑ Heart Racing or Skip Beats
- ❑ Dizziness
- ❑ Leg Heaviness or Cramping
- ❑ Persistent Sores on Legs
- ❑ Heart Burn
- ❑ Shortness of Breath
- ❑ Unusual Sweating
- ❑ Loss of Consciousness
- ❑ Leg Swelling
- ❑ Unusual Fatigue/Weakness

Do you have any of the following conditions?

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Family History of Heart Disease
- ❑ Heart Murmur or Heart Valve Problem
- ❑ Carotid Artery Disease
- ❑ Known Heart Disease
- ❑ High Cholesterol
- ❑ Smoking History
- ❑ PAD (Peripheral Arterial Disease)
- ❑ Varicose Veins
- ❑ Obesity
- ❑ Stroke History

Prevent Heart Disease!

www.samedayheartcare.com

Lansing Cardiovascular Consultants, P.C.

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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

Lansing Cardiovascular Consultants, P.C.

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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 $30 for up to 25 pages; $10 for a CD.
- **Disability/FMLA Forms:** A fee of $30 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 $10 charge.

No Show or Late Cancellation Charge

- For every no-show or late cancellation of an office testing without a minimum of 24-hour advance notice, there will be a $30 charge. More than 3 no shows and/or late cancellation can result in the termination of your care from our practice.