Cardiology Associates

Office Use Only: ☐ Ins Card ☐ DL ☐ HIPAA ☐ NP

Doctor/Location _____ Patient Number _____

PLEASE PRINT ---- PLEASE PRESENT INSURANCE CARD(S) AND DRIVER'S LICENSE TO RECEPTIONIST

Patient Information

Last Name_____ First Name_____ Middle Initial_____

Social Security #_____ Date of Birth_____ ❑Male ❑Female

Address_____ City_____ State_____ Zip Code_____

Email Address _____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____Address_____City_____State_____ Zip_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widow ❑Separated **Student:** ❑Full Time ❑Part Time

Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Native Hawaiian or Other Pacific Islander ❑White ❑Decline

Primary Language: ❑English ❑Spanish ❑Other ❑Decline **Ethnicity:** ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑Decline

Spouse/Guarantor Information

Last Name_____ First Name_____ Middle Initial_____

Social Security #_____ Relationship_____ Date of Birth_____ ❑Male ❑Female

Address_____ City_____ State_____ Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Employer_____Address_____City_____State_____ Zip_____

Insurance Information

Primary Insurance Company _____ Co-pay_____

Policy #_____ Group #_____ Effective Date_____

Name of Insured _____ Relationship_____ Date of Birth_____

Secondary Insurance Company _____ Co-pay_____

Policy #_____ Group #_____ Effective Date_____

Name of Insured _____ Relationship_____ Date of Birth_____

Does your Insurance require a referral? ❑No ❑Yes – If yes, referral number_____

Emergency Contact Information – Please list someone NOT living in the same household.

Name_____ Relationship_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Address _____ City_____ State_____ Zip Code_____

Primary Care Physician_____

Referred By: ❑Physician_____❑Relative/Friend ❑Self ❑Website ❑CA employee ❑Other_____

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It is understood that no oral or written contract exists which designates by name or description the individuals who will treat the patient. The individual who treats the patient may vary from time to time due to emergencies or the location at which the patient wishes to be seen. We will make every effort for you to be seen by the physician of your choice, but appreciate your understanding when it is not possible.

I hereby authorize Cardiology Associates to administer treatment and perform necessary procedures in diagnosing and/or treating my condition. Also, I hereby authorize the release of any medical information necessary for the processing of insurance. This assignment will remain in effect until revoked by me in writing. This assignment is to be considered as valid as an original.

Signature of Patient: _____ Date:_____

As a service to our patients, we will assist in filing insurance and obtaining reimbursement. However, all incurred charges remain the responsibility of the patient. In order to service your account or collect monies owed, our office and/or its agents may contact you using telephone numbers associated with your account, including wireless telephone numbers which could result in charges to you. Phone contact may include pre-recorded/artificial voice messages and/or automatic dialing devices. We may also contact you via text messages or e-mails.

I agree to these methods of communication being used to contact me regarding my account. I agree to pay all collection agency fees (up to 33.33%), in addition to necessary attorney fees and court costs. I waive now and forever my right of exemption under the laws of the constitution of the state of Alabama and any other state.

Signature of Patient: _____ Date:_____