Southern Indiana Heart and Vascular
Patient Registration Form

Date_____
Pharmacy name and Location_____

PATIENT INFORMATION: (*Use full legal name, no nicknames*)

Last Name_____ First Name_____ Middle Initial_____

Street Address_____

City_____ State_____ Zip_____

Mailing Address (if different from above)_____

City_____ State_____ Zip_____

Home Phone (____) _____- _____ Social Security #_____ Sex: ___M___F

Date of Birth_____ Marital Status_____

Employer Name and Address_____

_____ Work Phone (____)_____-_____

E-mail Address_____ Cell Phone (____)_____-_____

Emergency Contact _____ Emergency Phone (____)_____-_____

Who referred you? _____ Who is your family physician?_____

*** Centers for Medicare and Medicaid Services now <u>require</u> us to request the following information:**

Preferred language_____ Race_____ Ethnic Group_____ Refuse to provide___

FINANCIAL GUARANTOR: *Use this area **only** if someone else is financially responsible for your account.*

Last Name_____ First Name_____ Middle Initial_____

Address_____

City_____ State_____ Zip_____

Phone (____) _____- _____ Date of Birth_____ Sex: ___M___F

Relationship to Patient: ____ Spouse____ Parent____ Child _____Other

Please fill in above information completely and continue on back

Southern Indiana Heart and Vascular
Registration Form (Continued)

Please provide all insurance cards for copying, as well as photo ID and pharmacy card.

PRIMARY INSURANCE:_____

Policy Holder Name _____

* If Policy Holder is different from patient, complete info below.

Insured's Date of Birth_____

Insured's Relationship to Patient: ____Spouse____ Parent____ Child _____Other

SECONDARY INSURANCE:_____

Policy Holder Name _____

* If Policy Holder is different from patient, complete info below.

Insured's Date of Birth_____

Insured's Relationship to Patient: ____Spouse____ Parent____ Child _____Other

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits, including Medicare, Medigap, TRICARE and/or any third party carriers, to Columbus Regional Health Physicians, LLC for Southern Indiana Heart & Vascular services rendered to me or my dependents. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit and to inquire with my insurance to verify the providers at Southern Indiana Heart & Vascular are participating with my health plan. I understand and agree that I will be responsible for any co-pay, deductible or balance due that Columbus Regional Health Physicians, LLC is unable to collect from my insurance carrier for whatever reason.

Patient/Guarantor Signature X _____ Date_____

Please fill in above information completely and continue on next page ⇨

Southern Indiana Heart & Vascular
Patient Consents and Acknowledgements

CONSENT TO TREAT AND RELEASE INFORMATION:

I hereby consent and authorize medical services including evaluation, testing and treatment as directed by my Southern Indiana Heart & Vascular physician or their designee.

I authorize Southern Indiana Heart & Vascular to release information acquired during my evaluation and treatment to CMS, its agents, Medigap, and/or any third party carriers as necessary to secure payment of any benefits due. I understand that I have the right to rescind this authorization at any time by providing a written notification to Southern Indiana Heart & Vascular. **Patient initials** ☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I certify that I have received a copy of the Southern Indiana Heart & Vascular Notice of Privacy Practices. I understand that staff is available to answer any questions I may have concerning this notice. **Patient initials** ☐

CONSENT TO USE OF MAIL, PHONE, TEXTS OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls and texts and e-mail. I hereby authorize Southern Indiana Heart & Vascular to mail, call, text or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. **Patient initials** ☐

OPTIONAL - PERMISSION TO DISCLOSE MY PERSONAL HEALTH INFORMATION (PHI):

I grant permission to discuss my personal health information with the following person:

Last Name_____ First Name_____ Middle Initial_____

Phone (____) _____- _____ Date of Birth_____ Sex: ___M___F

Relationship to Patient: ____ Spouse____ Parent____ Child _____Other

Your signature below confirms that you understand and consent to each of the items above.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(If patient unable to sign - Caregiver, Parent or Legal Guardian)

NAME (PLEASE PRINT): _____ Date of Birth _____

Please continue on back

Southern Indiana Heart & Vascular
Patient Financial Responsibility Disclosures

Patient responsibilities include:

- **Information** – Accurate information regarding insurance and any changes in coverage must be provided to the front desk.
- **Co-pay and Deductibles** –You are responsible for paying your co-pay on the day service is rendered. As a courtesy, claims will be submitted to your health insurance plan.
- **Medicare (non-HMO)** –We accept Medicare assignment. You are responsible to pay the annual deductible and 20% co-payment. Claims will be submitted to your secondary insurance as a courtesy.
- **Non-Covered Services** – If we provide services to you that are not covered by your health plan, you will be responsible for payment in full. You may be required to sign a waiver.
- **Self Pay/No Insurance Coverage** –Payment in full is expected at the time of service.
- **Payment Arrangements and Plans** – Payment may be made with cash, check, Visa, MasterCard or American Express. Payment plans must be made with the Billing Department in advance or on the day of appointment.
- **Collections** – If it is necessary to assign your account to a collection agency, you will be responsible for any associated collection costs, including collection fees up to 30% of charges, reasonable attorney's fees and court costs. You understand that I may be contacted by the collection agency by any method of contact that you have provided, including your cellular phone number, which may result in charges from your wireless service provider. In addition, you may be dismissed from the practice.

Service Charge Fees – A service fee will be charged to your account for the following reasons:

- $20.00 – Returned check fee. If a second returned check occurs, the patient will be responsible for three (3) times the amount of check or $100.00, whichever is more.
- $200.00 – Fee for missed/ cancelled Nuclear Imaging Test without a minimum of 24 hours advanced notice. (Pharmaceutical drugs are ordered in advance specifically for each patient and cannot be used for another patient.)

Your signature below constitutes agreement to pay for any services and/or fees disclosed on these forms. Thank you for choosing Southern Indiana Heart & Vascular for your cardiology services.

Patient Signature: X_____ Date: X_____

Guarantor Signature: X_____ Date: X_____
(If different than patient)

Name (Please Print): X_____ Date of Birth _____

Southern Indiana Heart & Vascular
2325 18th St. Ste. 130 Columbus, IN 47201 (812) 379-2020