Northwest Cardiology Consultants, P.A.

21212 Northwest Fwy. Ste 555
Cypress, Tx 77429
Ph. 281-955-0786
Fax 281-955-8848

1631 North Loop West, Ste. 220
Houston, Tx 77008
Ph. 713-365-0786
Fax 713-426-6929

Patient Registration Form

Date: _____ ➔PRIMARY CARE PHYSICIAN: _____

PATIENT INFORMATION

Name: _____ Dob: _____
LAST FIRST MIDDLE

Address:_____ Zip code_____

Home ph: _____ Cell ph:_____ Work ph:_____

SSN#:_____ SEX: ☐Male ☐Female - Marital Status: ☐Single ☐Married ☐ Other

Race:_____ Language:_____ Ethnicity: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company: _____ Address: _____

ID_____ Group_____Employer_____Dob_____

Policy Holder Name: _____Relationship: _____ SSN_____

SECONDARY INSURANCE

Insurance Company: _____ Address: _____

I.D #:_____ Group #: _____ Ph_____

MEDICAL INFORMATION

➔PHARMACY PREFERENCE: _____Pharmacy Ph _____

Pharmacy Address: _____

Have you seen the Physician before ☐ Yes ☐ No If yes, Where _____

REFERRED BY: _____ **REASON FOR VISIT** _____

MEDICATION ALLERGIES _____

CURRENT MEDICATIONS_____

_____

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HOW DO YOU WANT US TO COMMUNICATE WITH YOU

□ Telephone: _____
□ Leave a detailed message
□ Leave a limited message to call back
□ Fax No. _____

□ Mail _____
_____
□ E-Mail _____

RIGHT TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

I AM GRANTING _____ MY _____ ACCESS TO MY PHI
(Person's Name) (Relationship)

_____ _____
(Signature) (Date)

PATIENT FINANCIAL POLICY

TO REDUCE CONFUSION AND MISUNDERSTANDING BETWEEN OUR PATIENTS AND PRACTICE, WE HAVE ADOPTED THE FOLLOWING POLICIES. IF YOU HAVE ANY QUESTIONS REGARDING THESE POLICIES, PLEASE DISCUSS THEM WITH OUR OFFICE MANAGER. WE ARE DEDICATED TO PROVIDING THE BEST POSSIBLE CARE AND SERVICE TO YOU AND REGARD YOUR COMPLETE UNDERSTANDING OF YOUR FINANCIAL RESPONSIBILITES AS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT.

FEES AND PAYMENTS

WE SHARE YOUR CONCERNS ABOUT RISING HEALTHCARE COSTS. OUR FEES REPRESENT USUSL AND CUSTOMARY CHARGES BASED ON COMMUNITY STANDARDS. PATIENTS ARE EXPECTED TO PAY FOR PROFESSIONAL SERVICES AT THE TIME OF THE VISIT. OUR POLICY IS TO COLLECT THE COPAY WHEN YOU ARRIVE FOR YOUR APPOINTMENT. ALL FORMS OF PAYMENT ARE ACCEPTED INCLUDING MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER AND CASH. WE DO NOT ACCEPT PERSONAL CHECKS. IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FEEL FREE TO DISCUSS THEM WITH US.

INSURANCE

WE HAVE CONTRACTS WITH MANY HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. WE WILL BILL THOSE PLANS & WILL REQUIRE THAT THE PATIENT PAY AUTHORIZED COPAYS, COINSURANCE AND DEDUCTIBLE AT THE TIME SERVICES ARE RENDERED. THE RESPONSIBILITY FOR PAYMENT OF MEDICAL CARE COST IS THE DIRECT RESPONSIBILITY OF THE PATIENT. ALL PATIENTS ARE RESPONSIBLE FOR FEES NOT PAYABLE. THE REMAINING BALANCE IS DUE WITHIN ONE MONTH OF NOTICE FROM THE INSURER. THE PATIENT IS RESPONSIBLE FOR OBTAINING AUTHORIZATION FROM HIS OR HER PRIMARY CARE PHYSICIAN. THE PATIENT IS RESPONSIBLE FOR UNDERSTANDING THE AUTHORIZATION PROCESS AND THE PAYMENT PROCESS OF HIS OR HER INSURANCE COMPANY

PHYSICIAN AUTHORIZATION & ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE **NORTHWEST CARDIOLOGY CONSULTANTS** TO RELEASE ANY INFORMATION AND DIAGNOSIS REQUESTED BY MY INSURANCE COMPANY. I UNDERSTAND THAT THIS INFORMATION WILL INCLUDE, WHERE APPLICABLE, SPECIFIC LABORATORY TEST RESULTS INCLUDING HIV INFECTION OR THE DIAGNOSIS OF ACQUIRED IMMUNE DEFICIENCY SYNDROME. I FURTHER AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN FOR THE SURGICAL AND/OR MEDICAL PAYABLE UNDER MY PLAN FOR SERVICES PROVIDED TO ME.

PRIVACY POLICY PROVIDED UPON REQUEST

_____ _____
Signature Date

_____
Printed Name of Patient

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Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all authorizations for Release of PHI			
Patient Name:	Date of Birth:	SS#	
Patient Address:			
City	State:	Zip	Phone:

Section B: I authorize Northwest Cardiology Consultants to **Release to: |___| Receive from: |___|**

Person/Organization:		Address:	
Recipients Phone No.	City	State	Zip

Section C: Description of Information to be disclosed

Description:	Date(s)	Description:	Date(s)	Description	Date(s)
All PHI in medical records History & physical Consult Report Operative Report Progress Note		Physician Orders Laboratory Imaging/Radiology Nursing Notes Medication Records		Demographics Special test/Therapy Itemized Bill Claim Forms Other:_____	

I understand that

1. I may refuse to sign this authorization and that it is strictly voluntary. If I refuse to sign, my records can not be released.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section D: Purpose of Disclosure

Continued Care _____ Attorney/Litigation_____ Insurance _____ Disability services _____
Other: _____

Section E: Signatures

I have read the above and authorize the disclosure of the protected health information as stated

Signature of patient/Guardian/Patient Representative:	***Date:***
Print Name of Patient's Representative	***Relationship to Patient***

This authorization will expire on the following: (fill in the date ore the event, but not both
Date: _____ Event _____
NOTICE OF PATIENT RIGHTS AND RESPONSIBILIES RECEIVED: YES / NO DATE: _____