Patient Registration Form

Patient Name: _____

DOB: _____ SSN: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Cell #: _____

Home #: _____ Work #: _____

Referring Doctor: _____

Primary Care Doctor: _____

Primary Insurance: _____

Policy/Member ID: _____

Group #: _____

Policy Holder: _____

DOB: _____ SSN: _____

Secondary Insurance (if applicable): _____

Policy/Member ID: _____

Group #: _____

Policy Holder: _____

DOB: _____ SSN: _____

EMAIL: _____

Gender: Male Female

Marital Status:

Single Married Divorced

Widowed Other

Employment Status:

Employed Unemployed Retired

Employer Name: _____

In Case of Emergency, Please Contact:

Name: _____

Relationship: _____

Cell #: _____

Home #: _____

How did you learn about us: Doctor TV Radio Newspaper Yellow Pages Internet Friend/Relative/Other: _____

I authorize a Cardio Texas, PLLC physician, and/or a mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist),and other health care providers, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Cardio Texas, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Signature: _____ Date: _____

Updated: June 12, 2015, replacing November 21, 2013 version

Consent for Treatment and Payment Agreement

I hereby authorize Cardio Texas to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Cardio Texas of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. *A* photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Cardio Texas, all insurance Or third party payments that I receive for services rendered to me immediately upon receipt. PatientInitial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Cardio Texas. Patient Initial: _____

I request this authorization also apply to all other insurance. Patient Initial: _____

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Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____ Social Security: _____

Release Records to:

Name: Cardio Texas, PLLC
Address: 1015 E 32nd St Suite 508
Austin, TX 78705
Phone: 512-807-3140 Fax: 512-469-0192

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to the party noted above.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Disclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire ninety (90) days from the date of my signature or as otherwise specified by date, event, of conditions as follows: _____

_____ _____
Signature of Patient Date

_____
Cardio Texas – Witness

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Cardio Texas

Acknowledgment of Test Result Follow-Up

As a patient of Cardio Texas, I understand that the Physicians and/or Clinical Nurse Specialists of Cardio Texas may order tests at other facilities.

These tests may include lab work, x-rays, ultrasound tests, etc.

I understand that it is ultimately my responsibility to follow up on the results of these tests. If I have a test performed and I do not get a call about the results of the test within two weeks. I must assume that the results were not sent to my Doctor. In recognition, I will then be responsible to call my Doctor's nurse at Cardio Texas to ascertain the results.

_____ _____

Patient Signature Date

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