EXCEL CARDIAC CARE

PATIENT REGISTRATION INFORMATION

Today's Date:_____

Last Name:_____ First Name:_____ Middle Name: _____ Suffix:_____

Other Name:_____ DOB:_____ SSN:_____ Sex:___ Marital Status:_____

Address:_____ City:_____ State:_____ Zip: _____

Home Phone(H):_____ Cell(C):_____ Work(W):_____Preferred:__H__W__C

Email Address:_____ Language: _____

Race (Circle One): White African American Asian American Native American Pacific Islander Other

Ethnicity (Circle One): Non-Hispanic/Latino Hispanic/Latino

Preferred Pharmacy:_____

INSURANCE INFORMATION

Patient's Relationship to Primary Policy Holder:_____

Primary Policy Holder Information (If different from above):

Last Name:_____ First Name:_____ Middle Name: _____ Suffix:_____

Other Name:_____ DOB:_____ SSN:_____ Sex:___ Marital Status:_____

Address:_____ City:_____ State:_____ Zip: _____

Primary Policy Information:

Name of Employer:_____Employer Phone: _____

Employer Address:_____ City:_____ State:_____ Zip: _____

Name of Insurance Company:_____

ID/Certification Number:_____ Policy/Group Number:_____

Issue Date:_____ Expiration Date:_____

Insurance Co. Address:_____ Phone:_____

Patient's Relationship to Secondary Policy Holder:_____

Secondary Policy Holder Information (If different from above):

Last Name:_____ First Name:_____ Middle Name: _____ Suffix:_____

Other Name:_____ DOB:_____ SSN:_____ Sex:___ Marital Status:_____

Address:_____ City:_____ State:_____ Zip: _____

Secondary Policy Information:

Name of Employer:_____ Employer Phone: _____

Employer Address:_____ City:_____ State:_____ Zip: _____

Name of Insurance Company:_____

ID/Certification Number:_____ Policy/Group Number:_____

Issue Date:_____ Expiration Date:_____

Insurance Co. Address:_____ Phone:_____

EMERGENCY CONTACT – RELATIVE NOT LIVING WITH YOU

Last Name:_____ First Name:_____ Middle Name: _____ Suffix:_____

Relation to Patient:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip: _____

CONSENT FOR TREATMENT

I authorize Excel Cardiac Care to examine me (or the patient for I am legally responsible) and to do any tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

AUTHORIZATION FOR RELEASE OF INFORMATION

Release of information for purpose of payment. I authorize Excel Cardiac Care to release to any billing agency, insurance company, health plan, or governmental agency such medical information that may be required to process my claim for payment of the medical bill.

Release of information for purpose of treatment. I further authorize Excel Cardiac Care to release appropriate medical information to any doctor, hospital, or other healthcare facility that has or will participate in my (the patient's) care. I authorize a photocopy, facsimile, or other electronic transmission of the above Assignments, Authorizations, and Releases to be used in place of the original until and unless I send written notice to the contrary to the offices of Excel Cardiac Care.

Release of information for purpose of operations. I further authorize Excel Cardiac Care to release or use all of my (the patient’s) information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation, and compliance with all federal and state laws.

I further authorize any other doctor, hospital, or health care facility to release to Excel Cardiac Care any medical information concerning my (the patient's) illness or injury.

ASSIGNMENT OF BENEFITS

I authorize any insurance company, or third-party payer (or Medicare) to whom a claim for payment has been submitted to pay any eligible benefits directly to Excel Cardiac Care. I hereby authorize payment go directly to Excel Cardiac Care of medical benefits payable by my insurance company (and/or Medicare) and understand that I am responsible for any charge not covered by the terms of my insurance policy.

I hereby assign Excel Cardiac Care full rights to represent my (the patient's) interests in any complaints of appeals of denial of benefits or reimbursement to the Texas Department of insurance (State Insurance Commissioner). I hereby authorize said assignee Excel Cardiac Care to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid.

I have read, understand, and do hereby agree to the terms of the forgoing Consents, Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION and INSURANCE INFORMATION I have provided is true and accurate to the best of my knowledge.

Patient's Printed Name	Date
Patient, Legal Guardian or Agent Signature	Relation if Signing for Patient

EXCEL CARDIAC CARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I have reviewed and understand Excel Cardiac Care **Notice of Privacy Practices** which explains how my medical information will be used and disclosed. A copy of Notice of Privacy Practices was made available to me.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices.

To release any information regarding patient to patient's relatives or agents, the practice must have permission from the patient. I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care.

Name	Relationship
_____	_____
_____	_____
_____	_____

_____

Date

_____ _____

Patient, Legal Guardian or Agent Signature

Relation if Signing for Patient

EXCEL CARDIAC CARE FINANCIAL POLICY

Excel Cardiac Care recognizes the importance of the successful operation of our practice. It is our hope that you will understand that our financial policy is a necessary part of assuring the financial resources required to maintain vital health care services for our patients and the community. Our goal is to set standards that will provide our patients with the highest quality of medical care.

- We participate with most insurance plans; however, it is your responsibility to know if we participate with your particular plan. We will bill your insurance company for medical services provided by our practice. It is the patient's responsibility to make sure we have the correct insurance information.
- **Co-payments, Co-insurance and deductibles are due at the time of the visit per your insurance contract unless prior billing arrangements have been made with the office.** We reserve the right to either reschedule the appointment or assess an additional surcharge of up to $15 in addition to the co-payment if we must bill the patient for the co-payment. We will bill the patient for any balances due from co-insurance or deductibles (but not co-payments) and expect all accounts to be paid within the initial billing cycle.
- If your insurance has referral requirements, you are required to have prior authorization or a referral from your Primary Care Physician (PCP) prior to your visit.
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you on an unassigned basis as a courtesy. This means your insurer may send the payment directly to you. Therefore our charges for your care and treatment are due at the time of service. We do not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company will pay. Any balance not covered by the insurance company becomes your responsibility.
- All health plans are not the same and do not cover the same services. Certain services performed by our office, for your benefit, may not be covered by your insurance plan. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility.
- A certain amount of time and preparation goes into your visit with our office. If you are unable to keep your appointment, please give us at least 48 hour notice. **We reserve the right to charge fees for either a missed appointment or an appointment not cancelled with a 48 hour notice. This fee is $200 for Myocardial Perfusion Imaging (Nuclear test). For all other appointment types the fee is $25.**
- Patients with no insurance coverage will be recognized as "Self Pay" patients. We expect all Self Pay patients to pay at the time of service unless other arrangements have been made.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For your convenience, we accept VISA, MasterCard, American Express, Discover, Diners Club, JCB, Union Pay and personal checks. Returned checks will incur a $30.00 service charge.
- Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account may be turned over to an outside collection agency.

I have read, fully understand, and agree to all the terms contained herein. I also understand and agree that the terms may be amended by the practice at any time without prior notification to the patient.

_____ _____

Patient's Printed Name Date

_____ _____

Patient, Legal Guardian or Agent Signature Relation if Signing for Patient