

PATIENT HISTORY

IDENTIFICATION

Name: _____ Age: _____ Date: _____
 Address: _____ Phone #: _____
 Referred By: _____

MAJOR COMPLAINT OR PROBLEM (Reason for visit)

CURRENT MEDICATIONS

DRUG ALLERGIES

HOSPITALIZATIONS OR SURGERIES

DATE	REASON	DATE	REASON

PAST MEDICAL HISTORY (Approximate Age of Onset)

Heart Attack _____	Hypertension _____	Tuberculosis _____	Liver Disease _____
Angina _____	Diabetes _____	Asthma _____	Frequent Indigestion _____
Heart Failure _____	High Cholesterol _____	Emphysema _____	Blood in Stool _____
Heart Murmur _____	Stroke _____	Chronic Bronchitis _____	Cancer _____
Chest Pain _____	Seizure/Convulsion _____	Pneumonia _____	AIDS/HIV _____
Shortness of Breath _____	Phlebitis _____	Pulmonary Embolism _____	Thyroid Disease _____
Palpitations _____	Kidney Stones _____	Chronic Cough _____	Anemia _____
Dizziness/Faintness _____	Kidney Infection _____	Ulcers _____	Gout _____
Loss of Consciousness _____	Kidney Disease _____	Gall Bladder _____	Psychiatric Treatment _____
Rheumatic Fever _____		Hepatitis _____	

FAMILY HISTORY

	Age	Illness	Cause of Death
Father	Alive/Dead		
Mother	Alive/Dead		
Brothers/Sisters	Alive/Dead		

HABITS

Smoking Packs/Day _____ How Long _____ When Stopped _____
 Alcohol Estimated Amount _____
 Caffeine Estimated Amount (Coffee, Tea, Soft Drinks) _____
 Diet Special Diets (Cholesterol, Diabetic, Salt) _____
 Exercise _____

PATIENT INFORMATION FORM

MARITAL STATUS CIRCLE ONE S M D W
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PATIENT NAME _____ BIRTHDATE _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ SOCIAL SECURITY _____

EMPLOYER _____ ADDRESS _____

NAME OF SPOUSE _____ ADDRESS _____

SPOUSE'S SOCIAL SECURITY # _____ DOB _____ PHONE _____

SPOUSE'S EMPLOYER AND ADDRESS _____

_____ WORK PHONE _____

RELATIVE OR FRIEND WE CAN CONTACT IN CASE OF AN EMERGENCY:

NAME _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY REFERRING PHYSICIAN

REFERRING PHYSICIAN _____ X _____

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A PRE-CERTIFICATION OR 2ND OPINION BEFORE ENTERING THE HOSPITAL, YOU MUST CONTACT YOUR REPRESENTATIVE TO MAKE ARRANGEMENTS. IF YOU DO NOT IT COULD MEAN THAT ALL OR A PORTION OF YOUR MEDICAL BILL WOULD NOT BE REIMBURSED TO YOU BY YOUR INSURANCE COMPANY. YOU MAY NEED ASSISTANCE FROM OUR OFFICE IN OBTAINING PRE-CERTIFICATION. LIST BELOW THE PRE-CERTIFICATION PHONE NUMBER PRINTED ON YOUR INSURANCE CARD.

PRIMARY INSURANCE-COMPANY NAME: _____

ADDRESS: _____

POLICY # _____ GROUP # _____

POLICY HOLDER NAME: _____ PRE-CERTIFICATION PHONE: _____

IN ORDER TO KEEP OUR CHARGES AS LOW AS POSSIBLE, WE EXPECT PAYMENT AT TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE

CHECK HOW YOU PLAN TO PAY TODAY: CASH CHECK CREDIT CARD

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and acknowledge receiving and reading a copy of the Financial Policy. I authorize payment of benefits to Atlanta Cardiology Consultants, P.C. To release any medical or other information necessary to process insurance claims. I further authorize photocopies of this form to be as valid as the original.

X _____ DATE: _____

I authorize Atlanta Cardiology Consultants, P.C. To release my records for the purpose of treatment, payment, and healthcare operations.

X _____ DATE: _____



OUR FINANCIAL POLICY

I acknowledge my financial responsibility to Atlanta Cardiology Consultants, P.C. for professional services rendered. I authorize Atlanta Cardiology Consultants, P.C. to furnish information to my insurance carrier concerning my health and/or treatments. I understand that Atlanta Cardiology Consultants, P.C. may file my insurance claim, and that this will be done in good faith and using appropriate diagnosis codes. I further understand that once this claim has been filed these codes can only be changed if there was an error in posting. Under no circumstances will CPT codes or diagnosis codes be changed at the patients request, as this may constitute fraud. All coding changes have to be approved by the physician and have to support medical guidelines.

Please be advised that all procedures performed at Atlanta Cardiology Consultants, P.C. are subject to the requirements of your insurance company. It is the patients' responsibility to understand the provisions of their insurance carrier. Essentially your insurance coverage is an agreement between you and your insurance carrier. We will help expedite your claim, but you are ultimately responsible for timely payment on your account.

You must realize:

- It is solely the patient's responsibility to confirm participation of Thomas S. Backer, M.D. / Katie Steffen, MMSC PA-C / Atlanta Cardiology Consultants, P.C. with your insurance plan.
- **It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. If the insurance requires referral, authorization, preauthorization or precertification prior to being seen or prior to having a procedure done, it is the responsibility of the patient to obtain such. NONPAYMENT OF SERVICES FOR FAILURE TO OBTAIN AN AUTHORIZATION, PREAUTHORIZATION REFERRAL, OR PRECERTIFICATION WILL BE THE RESPONSIBILITY OF THE PATIENT.**
- **It is your responsibility to keep us updated with your correct insurance information.**
- **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
- You are responsible for any and all co-payments, deductibles, and coinsurance as required by your insurance plan.
- Co-payments are due at the time of service, a \$20.00 service fee will be charged in addition to your co-payment if the co-payment is not paid at the time of service.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* ten (10) business days of receipt of your bill.
- If we do not participate in your insurance plan, payment in **FULL** is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- Self-pay patients are expected to pay for services in **FULL** at the time of the visit or when services are rendered
- Your insurance is a contact between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and in some instances, you will be responsible for these amounts. We will make every effort to ascertain your

coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

- Prior balances must be paid before your next scheduled appointment.
- If you participate with a high deductible health plan, be prepared to pay your deductible amount prior to your appointment, we will collect deductible's prior to check in.
- We accept cash, checks, Visa and MasterCard, and debit cards.

Medicare:

Our office accepts Medicare assignment. **We do not file secondary insurance.** Most secondary insurance carriers will automatically crossover from Medicare, it is the patient's responsibility to contact their secondary insurance carrier and request that this "automatic crossover" be setup.

Please Note:

Interest of 1% per month will be charged on all patient due balances that are 60 days past due until the balance is paid in full.

A fee of \$25.00 will be charged to patient account for all returned checks, plus any bank fees incurred.

We require 48-hour notice for canceling any appointments. A fee of \$50.00 will be charged to patient account for any cancellations with less than 48-hours notice. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in your dismissal from the practice.

Collections:

If necessary, any outstanding balance (**more than 60 days past due**) may be turned over to a collection agency or attorney at law for collection purposes. In such circumstances, the patient is fully responsible for payment of all remaining balances, legal or collection fees, plus interest as provided in O.C.G.A. 7-4-16.

Thank you for your cooperation,

Print Name

Responsible Party Signature

Date

Acknowledgement of Receipt of Privacy Practices

I, _____, have received or been given an opportunity to review a copy of Atlanta Cardiology Consultants, P.C. Notice of Privacy Practices.

Signature

Date

Patient Agreement for Communications

I, _____, understand that as part of my health care Atlanta Cardiology Consultants, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of a special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Atlanta Cardiology Consultants, P.C. to contact me in the following ways:

_____ Home Phone (voicemail) Number: _____

_____ Office Phone (voicemail) Number: _____

_____ Cell Phone (voicemail) Number: _____

_____ Fax Number: _____

I authorize Atlanta Cardiology Consultants, P.C. to speak with the following person/s and release information on my behalf:

I understand that Atlanta Cardiology Consults, P.C. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

Patient ID: _____ SSN: _____

Signature

Date

Patients Full Legal Name: _____ Date of Birth: _____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report this information, you may choose Refused/Unreported

(Please Check ONE in EACH CATEGORY that applies)

RACE	ETHNICITY	PREFERRED LANGUAGE
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More Than One <input type="checkbox"/> Undefined <input type="checkbox"/> Refused to Report/Unreported	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Undefined <input type="checkbox"/> Refused to Report/ Un-reported	<input type="checkbox"/> English <input type="checkbox"/> Hindi <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Urdu <input type="checkbox"/> Refused to Report/Unreported <input type="checkbox"/> Other: _____

Pharmacy Preference:

Name: _____

Location: _____

Phone Number: _____

Patient Portal Access: Decline

Please Provide an Email address for access to our Secure Patient Portal

Email Address: _____

Smoking Status:

Every Day Some Days Former Smoker Never Smoked

How Did You Hear About Us? (Please Check ONE that applies)

Family/Friend Online/Yellow Pages Hospital Newspaper

Existing Patient Self Referral Doctor: _____