ADVANCED CARDIOLOGY, LLC & ADVANCED PRIMARY CARE

Welcome to our office. Please complete all forms, present ALL insurance cards and ID. Thank you.

Date:	Patient Last Name, First Name & Middle Initial (Legal name)	Date of Birth	Age	Social Security Number

Patient Mailing Address -Include Apt, Ste or Flr

Town State Zip code:

Patient Home Phone Number	Patient Work Number	Patient Cell:
( )	( ) Ext.	( )

Preferred contact number:	Patient email:	***Preferred*** method for invoice:
☐ Home ☐ Work ☐ Cell		☐ Text ☐ E Mail ☐ Paper

Patient Sex:	Patient is:	Preferred Language:
☐ Male ☐ Female	☐ Employed ☐ Retired	☐ English ☐ Spanish ☐ Other

Race:

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

☐ Unknown ☐ Other ☐ Decline

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Decline

Patient is:	Spouse Name:	Patient Relationship to Insured:
☐ Single ☐ Married ☐ Widowed ☐ Other		☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY Insurance	Member ID Number		Required Lab By Insurance
Policy Holder Name	Policy Holder Birth Date	Referral Required? ☐ Yes ☐ No	Specialist Copay/PCP Copay
SECONDARY Insurance	Member ID Number		Required Lab By Insurance
Policy Holder Name	Policy Holder Birth Date	Referral Required? ☐ Yes ☐ No	Specialist Copay/PCP Copay
TERTIARY Insurance	Member ID Number		Required Lab By Insurance
Policy Holder Name	Policy Holder Birth Date	Referral Required? ☐ Yes ☐ No	Specialist Copay/PCP Copay

Primary Care Physician	Referring Physician

Pharmacy	Address	City	State

Emergency Contact	Relationship

Home#	Cell#	Work#

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS & PRACTICE POLICIES

- I authorize the release of information necessary to *any and all* entities to secure the payment of benefits submitted for services rendered by Advanced Cardiology, LLC & Advanced Primary Care, on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree that my signature on this document authorizes all claims to be submitted for benefits for all services rendered without obtaining my signature for each claim. I assign directly to Advanced Cardiology, LLC & Advanced Primary Care payments for all services rendered. I also authorize Advanced Cardiology, LLC & Advanced Primary Care and Advanced Electronic Medical Billing, Inc., to file a complaint on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.

- **I understand I am financially and fully responsible for all charges if my insurance carrier denies payment for any reason.** I understand I am responsible for any deductibles, coinsurance or copays according to my benefit plan. **I understand copays are due at the time of visit.** I understand that a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment terms are made. I understand I must contact my insurance company prior to services rendered, to determine if the provider participates with my specific plan, determine referral or pre-authorization needs, and understand my coverage limits. In the event my insurance carrier issues payment directly to me, I agree to pay Advanced Cardiology, LLC & Advanced Primary Care in the same amount plus any co-pays, deductible/coinsurances due. I agree to send in payment upon receipt of payment. Credit balances will remain on file and applied to future balances unless a refund is requested in writing.

- An appointment slot has been allocated for you and is not available for other patients. We require 24 hours advance notice of all cancellations. A charge of $30.00 will be incurred if not cancelled within 24 hours advance notice. Reminders calls are a courtesy, it is your responsibility to remember your appointment.

- Telephone prescription refills must be requested Monday-Friday between 9:00am and 4:00pm. Please allow 24-48 hours for your order to be called in. Telephone refills may be delayed due to the need for the physician to review your record. The office staff at Advanced Cardiology, LLC & Advanced Primary Care will return patient phone calls received before 4:00 pm Monday through Friday before the office closes that day. Calls received after this time will be returned the next business day. If you require urgent attention, proceed to the nearest hospital or call 911.

- I agree to provide Advanced Cardiology, LLC & Advanced Primary Care with all current insurance (s) and provide changes within 30 days from service. I understand that if a claim is not paid because of my failure to provide correct insurance information, I am responsible for the charges. I understand that if my insurance carrier denies payment due to a coordination of benefit regarding other coverage, or any other reason, I will be responsible for all outstanding balances.

- I understand that payment is due upon receipt of my monthly statement. I understand that I will be legally responsible for any and all collection and attorney fees on all balances due necessary for the collection of payment, in addition to any returned check fees.

- Consent for treatment: I authorize Advanced Cardiology, LLC & Advanced Primary Care to furnish any and all medical and/or surgical treatment of those mentioned, considered medically necessary in the treatment of the patient identified below while a patient at Advanced Cardiology, LLC & Advanced Primary Care.

This agreement has no term date and will remain in force until such time as a new agreement is signed.

SIGN HERE X _____ _____

Patient or Guarantor Signature (Must be 18 Years of Age)	Date	Relationship to Patient

Financial guarantor (print name)	Date of Birth	Guarantor Social Security#
Financial Guarantor address -Include Apt, Ste or Flr		
Cell #	Home #	Work #

Advanced Cardiology, LLC & Advanced Primary Care
Notice of Privacy Practices Acknowledgement & Designation of Disclosure

I have received a copy of Advanced Cardiology, LLC & Advanced Primary Care Notice of Privacy Practices. I hereby sign and consent to the use or disclosure of my protected health information by, or on behalf of, Advanced Cardiology, LLC & Advanced Primary Care for purposes of treatment, payment or healthcare operations. I understand my protected health information may be used for such purposes without my written authorization. I authorize Advanced Cardiology, LLC & Advanced Primary Care, and billing agent, to send/leave voice messages, or communicate in writing regarding my medical care. This form is effective upon execution and will remain in effect unless revoked by me.

PATIENT/FAMILY CONTACT LIST

Print Patient Name:_____ Date of Birth: ____/____/____

CONTACTS

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

NAME:_____

RELATIONSHIP:_____

CELL: _____ HOME: _____ OTHER: _____

SECONDARY CONTACT

NAME:_____

RELATIONSHIP:_____

CELL: _____ HOME: _____ OTHER: _____

TERTIARY CONTACT

NAME:_____

RELATIONSHIP:_____

CELL: _____ HOME: _____ OTHER: _____

☐ I decline to designate a representative at this time

COMMENTS/OTHER INFORMATION

_____

_____

_____

This form is effective on execution and will remain in effect unless revoked by me in writing.

Patient Signature: _____ Date:____/_____/_____ Time: _____