

Cardiology Associates of Savannah, L.L.C.

10 Oak Forest Rd. Suite. B Bluffton, SC 29910	11700 Mercy Blvd, Bldg. 6 Plaza D Savannah, GA 31419	604 B East long Street Claxton, GA 30417	600 East Oglethorpe Hwy Hinesville, GA 31313	400 Cedar Street Metter, GA 30434	101 Harris Industrial Blvd, Suite A Vidalia, GA 30474	459 Hwy 119 South Springfield, GA 31329	802 Towne Park Dr. Rincon, GA 31326	105 Grand Central Blvd suite 108 Pooler, GA 31322
---	--	---	--	--	---	--	--	---

This is to confirm that _____ has an appointment with:

<input type="checkbox"/> Dr. John Rathbun	<input type="checkbox"/> Dr. William Wallace	<input type="checkbox"/> Dr. Michael Chisner
<input type="checkbox"/> Dr. Karen Hanna	<input type="checkbox"/> Dr. Gary Elkin	<input type="checkbox"/> Dr. Claude Su
<input type="checkbox"/> Dr. Michael Babcock	<input type="checkbox"/> Dr. Daniel Cobb	<input type="checkbox"/> Device Clinic

On _____ at _____ A.M./P.M.

Location: Savannah Claxton Hinesville Metter Vidalia
 Pooler Springfield Bluffton Rincon

To ensure speedy check-in time, we ask our new patients do the following:

1. **Please arrive 20 minutes before your appointment time** to allow to fill out your new patient paperwork and to ensure that your information is entered into the system in a timely manner.
2. Please **bring your insurance cards, photo ID and a list of all medications** you are currently taking.
3. **It is the patient's responsibility to obtain any insurance referrals or authorizations prior to your appointment.**
4. Self-pay/uninsured patients are **required to bring in a \$150.00 deposit** for their initial consultations/office visit. Any remaining balances must be paid by making payment arrangements through our billing office.
5. Failure to notify our office within 24hrs prior to your appointment time will result in a \$50.00 cancellation fee.

We thank you for your cooperation, and we look forward to meeting your medical needs. If you have any questions or concerns, please feel free to call us at **912-927-3434** or toll free at **1-888-472-5722**.

History Form

NAME: _____ AGE: _____ SEX: _____ MARTIAL STATUS: _____

OCCUPATION: _____ REFERRING PHYSICIAN: _____

PRESENT ILLNESS: (Describe briefly the problems you are having and the reason you are here today.)

MEDICATIONS: (List or attach a list of all medication you are now taking, the dosage and how frequently you are taking them.)

ALLERGIES: (List all medication allergies such as penicillin, iodine, etc.)

PAST HISTORY:

MEDICAL: (List all major illness you had in the past.) _____

SURGICAL: (List Any heart related (Bypass, Stents, Valve surgery, Pacemaker) surgeries you had and the approximate dates they occurred.) _____

SOCIAL HISTORY:

Tobacco Use:

_____ Current Smoker: _____ packs/day

_____ Previous Smoker

_____ Never Smoked

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Cardiovascular

- Chest Pain
- Palpitations/Fluttering
- Shortness of breath

Endo

- Cold /Heat Intolerance

Neurological

- Headaches
- Memory Loss
- Fainting
- Disorientation
- Dizziness
- Lack of Coordination
- Numbness/Tingling
- Weakness

Genitourinary

- Frequent Urination
- Bloody Urination
- Nighttime Urination

Eyes

- Change in Vision

Skin

- Skin Bruising

Constitutional

- Recent Fever/Sweats
- Fatigue/Weakness
- Weight Loss/Gain

Gastrointestinal

- Heartburn/Reflux
- Nausea/Vomiting

Respiratory

- Cough/Wheezing
- Coughing Oxygen
- Use Oxygen
- Use CPAP/BiPap
- Snoring
- Do not feel rested in the morning

FAMILY HISTORY: (List major illness: Heart Disease, Hypertension, Congestive Heart Failure, Stroke, Heart Surgery (Bypass, Valve), Stents, Other.)

Father: _____

Mother: _____

Brothers/Sisters: _____

- NEW PATIENT REGISTRATION -
Cardiology Associates of Savannah

Date: _____ Primary Physician _____ Pharmacy: _____

PATIENT INFORMATION

First Name Middle Last Name

Other Names Used Email Address Marital Status
(S, M, W, Sep, D)

Date of Birth Sex Race Primary Language Ethnicity Social Security No.
(MM/DD/YY) (Circle One) (XXX-XX-XXXX)

Patient Mailing Address (Street, Route, Apt. No.) City State Zip Code

Primary Phone Number Secondary Phone Number *Please provide at least two (2) phone numbers

Emergency Contact Name Phone Number Relation to Patient
(Must be different from primary phone number on file)

INSURANCE INFORMATION

Primary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

Policyholder's Name Date of Birth Employer Relation to Patient
(MM/DD/YY)

Secondary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

Policyholder's Name Date of Birth Employer Relation to Patient
(MM/DD/YY)

How did you hear about our office? Check One:
 Referring Doctor Newspaper Billboard Radio Phone Book Website
 Friend - Who may we thank: _____
 Other: _____

**ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTIFICATION FORM**

Signature below is acknowledgement that have been given and had the opportunity to read our Notice of Privacy Practices. Should you wish to read the Notice at any other time, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgment and authorization remains in effect until we are notified, in writing, by you of any changes.

Print Name _____ Date _____

Signature _____ DOB _____

Please list all additional authorized persons with whom we may discuss any of your medical information (this includes scheduled appointments):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

LAB PROCEDURES

This clinic may utilize an outside lab to process lab-related services that cannot be performed in our office. In that case you and/or your insurance company will receive a bill from the outside lab for your lab work.

To avoid out-of-network charges, which will result in additional cost to you, please let your doctor or the nurse know **immediately** if your health insurance policy requires us to send your lab work to another lab. Patients or guardians are responsible for communicating this insurance requirement to our staff at each appointment.

I have read and understand the above two Notices. I also understand that I will be responsible for all charges incurred related to out-of-network lab services.

Patient Name (please print) Date Patient/Guardian Signature

CARDIOLOGY ASSOCIATES OF SAVANNAH, L.L.C.

PATIENT RECORD OF DISCLOSURES

In general, the H.I.P.A.A. privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI)

Patient Name _____

E-Mail Address _____

Primary Care Physician _____

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____

- Okay to leave message with detailed information.
- Okay to leave message with call back number only.

Work Telephone _____

- Okay to leave message with detailed information.
- Okay to leave message with call back number only.

Cellular Phone _____

- Okay to leave message with detailed information.
- Okay to leave message with call back number only.

Written Communication

- Okay to mail to my home address.

Address: _____

- Okay to mail to my work/office.

Address: _____

- Okay to fax to this telephone number.

Number: _____

GENERAL CONSENT FORM

Cardiology Associates of Savannah
And/Or
Affiliated Entities

Patient: _____ DOB: _____ Today's Date: _____

I, the undersigned, agree to the following:

(1) CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic, laboratory, imaging, examinations and surgical procedures and treatment by my physicians/nurse practitioner, his/her assistants, designees or consultants, as may be necessary in the judgment of my physician/nurse practitioner. I also understand that I will be billed directly for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(2) RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES

Cardiology Associates of Savannah and this clinic are not responsible for valuables, including money, jewelry, glasses, dentures, documents and other personal items.

(3) RELEASE FROM RESPONSIBILITY

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(4) AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, Center for Medicare and Medicaid services, or any other parties that may be liable for all or part of the Clinic's charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic and utilization review nurse or case manager who may not be an employee of the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment and payment of services rendered.

(5) NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Clinic's Notice of Privacy Practices. My signature below acknowledges receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(6) ASSIGNMENT OF BENEFITS

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payors for the payment of all charges associated with my treatment. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to billing insurance, filing petitions, filing suit in name or on behalf of the Clinic or its assignees, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Party payor, the patient or guarantor.

(7) FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible to the Clinic and its lawful assignees for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other Third Party Payor are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. Unless payment is made in full at the time of service, then patient authorizes the Clinic or its agents to obtain a credit report. Should the account be referred for collection to a collection agency, the undersigned agrees to pay all court costs of collection may include reasonable attorney fees of up to and including 15% of the debt involved. The undersigned patient and insured also agree that the Clinic or its assignees may apply any payments received from the patient against any other amounts due at the time from or for the undersigned patient. All amounts not paid when due may accrue interest at the rate of 1½% per month on the unpaid principal balance. If applicable, I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(8) NON-CERTIFICATION OF SERVICES

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies either all or part of their payment on the clinic account, I will pay the account in full upon demand.

(9) CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING

I authorize the clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(10) MEDICAL EXCHANGE OF INFORMATION

I hereby authorize the Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care.

(11) ACKNOWLEDGMENT

My signature below constitutes my acknowledgment and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent form will be valid and remain in effect as long as I am a patient of the Clinic.

I certify that I have read the foregoing, and I am either the patient or am duly authorized by the patient's general agent to execute the above and accept the terms.

Signature of Patient or Authorized Individual

Date

Relationship of Signer to Patient:

(self, mother, father, son, daughter or explain other)

Guarantor of Payment (If patient not signing)

If patient is unable to sign, state reason: _____

Witness

Date

NEW PATIENT REGISTRATION – ACKNOWLEDGEMENT AND DISCLOSURES
Cardiology Associates of Savannah

PHYSICIAN PRACTICES POLICY AND RELEASE OF INFORMATION

The following is a statement of our Financial Policy for services provided within our office and does not apply to any testing or diagnostic procedure performed outside of the physician practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.**

Initial: _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial: _____

When you receive a statement, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you must contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial: _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for our office to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator and/or other health benefit payor or representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization serves as permission to obtain a copy of your complete medical record for or from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, by communicating to the practice either in writing or verbally, followed by a written withdrawal.

Initial: _____

I understand that I am financially responsible for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits or claims to be paid directly to this office.

PATIENT NAME (PLEASE PRINT)

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE