West Georgia Cardiology

Patient History Form

Patient's Name: _____ Social Security #: _____

Primary Care Doctor: _____ Allergies: _____

Past Medical History

(A) Have you ever had problems with any of the following areas? Circle ALL that apply.

Eyes Ears Nose Throat Neck Heart Lungs Stomach

Digestion Bowels Kidneys Muscles Joints Bones Other_____

(B) Have you ever had any of the following conditions? Circle ALL that apply.

Diabetes Heart Attack Stroke Congestive Heart Failure Cancer

High Blood Pressure Pleurisy Arthritis High or Low Thyroid Blood Clots

High Cholesterol Other_____

(C) List any surgeries you have had: _____

_____

Family History

(A) Has anyone in your family ever had problems with any of the following areas? Circle ALL that apply.

Eyes Ears Nose Throat Neck Heart Lungs Stomach

Digestion Bowels Kidneys Muscles Joints Bones Other_____

(B) Has anyone in your family ever had any of the following conditions? Circle ALL that apply.

Diabetes Heart Attack Stroke Congestive Heart Failure Cancer

High Blood Pressure Pleurisy Arthritis High or Low Thyroid Blood Clots

High Cholesterol Other_____

Social History

(A) Do you smoke? ☐ *Yes* ☐ *No* *If yes, then how much?* _____

(B) Do you use smokeless tobacco? ☐ *Yes* ☐ *No* *If yes, then how much?* _____

(C) Do you use alcohol? ☐ *Yes* ☐ *No* *If yes, then how much?* _____

(D) Do you use street drugs? ☐ *Yes* ☐ *No* *If yes, then how much?* _____

(E) Do you have cultural or religious requirements regarding healthcare? ☐ *Yes* ☐ *No*

(F) What type of work do you do? _____

Patient/Guardian Signature: _____ Date: _____

West Georgia Cardiology

REGISTRATION FORM

Section I: Patient Information **Date**_____

Physician Name: _____
Name: _____ I Prefer to be called: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
The best time to contact me is: _____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Email Address_____
Date of Birth: _____ Social Security Number: _____
Will you require an interpreter? ☐ Yes ☐ No Native Language: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Whom may we thank for referring you? _____
Person to contact in case of emergency: _____ Phone: _____
Your preferred pharmacy's name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____
Employer_____ Work Phone (____) _____ SSN#_____

Section III Insurance Information

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City_____ State:_____ Zip _____
Insurance Company_____ HIC/Policy/ID#_____
Group Name: _____ Group #_____
Claim Address: _____ Insurance Phone: _____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____ DOB_____ Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____)_____
Address of Employer: _____ City_____ State:_____ Zip _____
Insurance Company_____ Group #_____ ID#_____
Claim Address: _____ Insurance Phone: _____

PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID TO BE COPIED.
PAYMENT IS EXPECTED AND APPRECIATED AT TIME OF SERVICES.

West Georgia Cardiology

Authorization For Use/Disclosure of Protected Health Information

I hereby request and authorize (*print name of hospital/physician*): _____ Phone # _____

Fax #: _____ to:

Provide **copies** of my records to:
West Georgia Cardiology
129 Bankhead Highway, Carrollton, Georgia 30117
Fax #: (770) 838-8443 Phone #: (770) 838-8440

This authorization applies to records or WGC access from the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but **may include** other detailed mental health information, HIV/AIDs information and/or information regarding alcohol or substance abuse.

◊ Entire Medical Record	◊ Doctor's Orders	◊ Pulmonary Function Test
◊ **Abstract of Records****	◊ Electro Cardiogram (ECG/EKG) Report	◊ Radiology Reports
◊ Cardiac Cath Report	◊ Emergency Room Report	◊ Stent/Bypass Report
◊ Cardiac Rehab	◊ History & Physical Report	◊ Stress Tests
◊ Consultation Report	◊ Laboratory Test Results	◊ Ultrasound _____
◊ Coumadin Reports	◊ Medication Records	◊ Diagnostic Reports
◊ Discharge Summary Reports	◊ Operative Report	◊ Other-Specify _____
◊ Demographics	◊ Pacemaker/ICD Implant Report	◊ Notes-Specify _____

****An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Report, and diagnostic test results.**

Purpose of Use or Disclosure: ◊ At the request of the individual (patient)
◊ Other _____

The following information is needed to assist the provider in location the patient's records:

Patient's Full Name: _____ Patient's SSN: XXX-XX-_____
Maiden/Other Name: _____ Patient's Date of Birth: _____
Patient's Phone # (Home): _____ (Work): _____ (Cell): _____
Current Address: _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from the Medical Records Department. The completed revocation must be presented to the Medical Records Department. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. WGC Providers shall not condition treatment on the receipt of this Authorization, except when such conditions is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams.)

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here** _____

_____ _____ _____
Patient's or Legal Representative's Signature **Please Print Name** **Today's Date**

As Legal Representative, my relationship to the patient is _____. Any document providing such authority must be attached. The patient is unable to sign because _____.

Note: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for records requests to be processed, however records for treatment purposed can be immediately faxed to the patient's healthcare provider when requested.

West Georgia Cardiology

Financial Policy

Revised 7/23/12

West Georgia Cardiology (WGC) is committed to providing you high quality medical care in a cost-effective manner. In order to accomplish this, we depend upon you to promptly pay for your services received at our location.

- Insured Patients: If you have coverage, as a courtesy WGC will file all claims directly with your insurance company and will assist you in obtaining the maximum fair reimbursement for the services rendered.

  In order to provide this service to you, we must have all of your current insurance data. Insurance cards must be presented at each visit. Patient with insufficient insurance data will be registered as Self Pay and payment in full will be expected at the time of service.

  We are required by our contract with your Insurer to collect your portion of the visit's charges. **It is your responsibility to pay any deductible, co-payment, or any portion of the charge as specified by your plan at the time of service.** Any medical services not covered by the patient's plan are the patient's responsibility. Should your Insurer later deny the claim, you are fully responsible for paying the charges, or making financial arrangements with our Business Office within 15 days of our statement.

  WGC participates with most of the area insurance plans. If you have insurance that we do not participate in, we will still file a claim out of courtesy, however, it may impact your deductible and/or co-payment. We encourage you to contact your insurance company in advance to determine your payment.

  MEDICARE AND VA BENEFICIARIES: Please note if you have both of these insurances we can only file our claims to one. Thus, we will file our claims to Medicare due to our appeal rights. If there is a balance left from Medicare and you do not have a Tertiary insurance, you will be responsible for payment. You can bill the balance to the VA for reimbursement.

- Self Pay Patients: Patients with no insurance coverage or proof of coverage are expected to pay in full at the time of service **in the form of cash, credit card, or money order only** unless prior arrangements have been made. Please call our Business Office at (678) 839-7290 in advance to make arrangements for payment.

  PATIENT FINANCIAL ASSISTANCE PROGRAM: Our Indigent Program is based on an individual's household income. The program runs per calendar year. Each year you will need to sign a new contract for approval. If you are enrolled in our Indigent Program you are required to pay your specified co-payment at the time of service.

- Fees:

  - You will be responsible for a No-Show fee of $25.00 if your appointment is not cancelled or rescheduled in 24 hours prior to your appointment time, for the following services: Office visits, Massage therapy, all other test not listed. This amount will not be billed to your insurance company.
  - If you are scheduled for any nuclear stress test, you will be responsible for a No-Show fee of $180.00 if your appointment is not cancelled 24 hours prior to your scheduled test. This amount will not be billed to your insurance company.
  - You will also be responsible for a fee of $180.00 if you fail to follow the instructions given prior to your scheduled test. This amount will not be billed to your insurance company.
  - If your account is forwarded to an outside collection agency you will be responsible for a collection fee of 35% in addition to your balance.

- Billing Inquiries: Our practice believes that a good patient/physician relationship is based on understanding and communication. Questions about this financial policy or financial arrangements may be directed to our Business Office at (678) 839-7290.

  We are glad to assist in any way possible; however, some specific coverage questions can only be addressed by your insurance company's member services department.

I have read and understand this explanation of my financial responsibility for services I receive from WGC:

_____ _____/_____/_____

Patient Signature Date

West Georgia Cardiology

TO ALL OUR PATIENTS:

West Georgia Cardiology is dedicated to ensuring your privacy.

Please review the following questions and inform the Front Desk staff of any changes that may apply to you:

1. Do we have permission to leave a message on the phone number(s) you have provided us?

   _____ Yes or _____ No

2. May we discuss your medical information with family and friends?

   _____ Yes or _____ No

   If yes, with whom: _____

   _____

   _____

3. If someone calls for you or comes and asks for you while you are here, do we have permission to tell them you are here?

   _____ Yes or _____ No

4. May we discuss your financial information with family and friends?

   _____ Yes or _____ No

   If yes, with whom: _____

   _____

   _____

Signature: _____

Date: _____

Thank you for your cooperation,

West Georgia Cardiology

Thank you for choosing **West Georgia Cardiology** as *your cardiac care provider.*

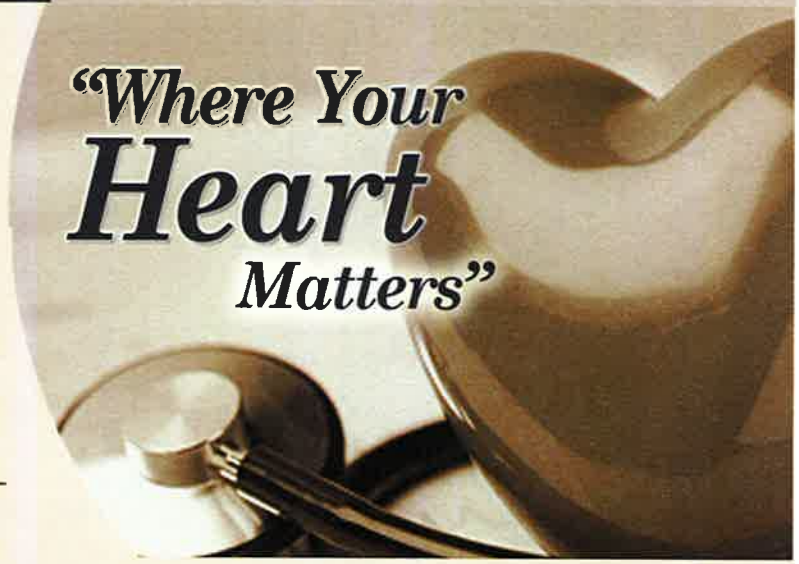
West Georgia Cardiology

westgacardiology.com

Date:

How did you hear about us?

- ☐ Internet
- ☐ Website
- ☐ Employer
- ☐ Insurance Company
- ☐ Emergency Room
- ☐ Family or Friend
- ☐ Self
- ☐ Other (specify) _____



Patient's Name:

Date of Birth: