Account # ____________

Tyler Cardiovascular Consultants, P.A.

EXPERIENCE. HEALING.

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: ______________ First: ______________ MI: ________

Address: ______________ City: ____________ State: ______ Zip: ________

Home #: ____________ Work #: ____________ Cell #: ____________

Date of Birth: ____________ SS #: ____________ Gender: ☐Male ☐Female

Ethnicity: ____________ DL #: ____________ E-Mail Address: ____________

Employer Name & Address: ______________________ Occupation: ____________

Martial Status: ______________ Spouse's Name: ______________

Referring Physician: ______________________ Phone#: ____________

Primary Care Physician: ______________________ Phone #: ____________

INSURANCE INFORMATION:

Primary Insurance Name & Address: ______________________________

Policy #: ____________ Group #: ____________ Network: ____________

Name of Insured: ______________ Relationship to Patient: ______________

SS #: ____________ DOB: ____________ Occupation: ____________

Policyholder's Employer Name & Address: ______________________________

Secondary Insurance Name & Address: ______________________________

Policy #: ____________ Group #: ____________ Network: ____________

Name of Insured: ______________ Relationship to Patient: ______________

SS #: ____________ DOB: ____________ Occupation: ____________

Policyholder's Employer Name & Address: ______________________________

IN CASE OF EMERGENCY, CONTACT:

Name: ______________ Relationship to Patient: ____________ Phone #: ____________

Patient initials _____

Continued on back

01/08

Account # ____________
DOB: ____________

PATIENT AUTHORIZATION

INITIALS

CONSENT TO TREATMENT

☐ I voluntarily consent to receive medical and health care services provided by Tyler Cardiovascular Consultants that my physician deems necessary in my diagnosis and treatment. I understand that such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as a result or cure. I also acknowledge that I may see a physician extender while under the care of Tyler Cardiovascular Consultants.

ASSIGNMENT OF BENEFITS

☐ I assign all insurance benefits for medical and health care services I am rendered by the physicians and/or staff of Tyler Cardiovascular Consultants to be made payable to Tyler Cardiovascular Consultants, PA. I certify that I have provided complete information in regards to all insurance coverage I am currently covered by.

FINANCIAL RESPONSIBILITY

☐ I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare, Medicaid, or other third party payor and agree to make payment as requested by Tyler Cardiovascular Consultants.

HIPAA Notice of Privacy Practices

☐ I acknowledge that I have been given access to a copy of Tyler Cardiovascular Consultants' Notice of Privacy Practices.

This consent/assignment/authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

______________________________	______________
Patient/Legally Authorized Person Signature	Date
______________________________	______________
Print Name and Relationship to Patient	Witness

Patient Authorization for Disclosure of Protected Health Information

I, ________________________________, hereby authorize Tyler Cardiovascular Consultants' medical staff to disclose or provide protected health information to myself, any of the individuals listed below, or the physician(s) listed on this form via phone, fax, mail, or email addresses. I authorize CVC to disclose appointment information or financial obligations to individuals, phone numbers, or addresses listed on this form. I understand this authorization will remain in effect until I choose to submit in writing that I wish to have it revoked.

Designated Individual(s)	Relationship to Patient
______________________________	______________
______________________________	______________
______________________________	______________

☐ I do NOT want CVC to disclose any protected health information via email.

______________________________	______________
Patient Signature	Date

01/08