Virginia Cardiovascular Group

12330 Pinecrest Rd # 125
Reston, VA, 20191

Tel: 703-822-5250 Fax: 571-252-5595

PATIENT REGISTRATION FORM

PATIENT NAME LAST	FIRST	MIDDLE INITIAL		PATIENT DATE OF BIRTH
HOME ADDRESS	APT. NO	CITY	STATE	ZIP CODE
OCCUPATION ☐ EMPLOYED ☐ RETIRED ☐ STUDENT	SOCIAL SECURITY #	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX ☐M ☐F	HOME PHONE [ ] Preferred
EMPLOYER	E – MAIL ADDRESS			WORK PHONE [ ] Preferred
				CELL # [ ] Preferred
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE :			

PRIMARY INSURANCE INFORMATION

SUBCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
PRIMARY INSURANCE COMPANY NAME		SOCIAL SECURITY # OF SUBSCRIBER:	
INSURANCE ID OR POLICY #	GROUP / CODE	EFFECTIVE DATE	
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)			
CITY	STATE	ZIP	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
PRIMARY INSURANCE COMPANY NAME		SOCIAL SECURITY # OF SUBSCRIBER:	
INSURANCE ID OR POLICY #	GROUP / CODE	EFFECTIVE DATE	
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)			
CITY	STATE	ZIP	

PATIENT AUTHORIZATION

I, _____, hereby authorize Virginia Cardiovascular Group to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Virginia, Medicare, and / or _____ Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).
(Name of other insurance company)

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.
(Name of Medigap Carrier)

_____ _____

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

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Is this visit a **Workman's Compensation case**? (circle one) YES NO

If yes;

Date of accident_____ W/C Ins. Company_____

Where:_____ When _____

Did you file claim? YES NO Claim #_____

Is this visit due to an **Auto Accident**? (circle one) YES NO

If yes;

Date of accident_____ Auto Insurance_____

Where:_____ When _____

Did you file claim? YES NO Claim # _____

Assignment of Benefits and Authorization to Release Medical Information

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **Virginia Cardiovascular Group**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for any collection cost, attorney fees, litigation fees and court costs. I hereby authorize **Virginia Cardiovascular Group** and its employees and agents, To release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

Signed (Insured Person) _____Date_____

Responsible Person if Patient is a Minor _____

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Office Policy Information Sheet

Name of Patient: _____

PLEASE NOTE: All charges and/or fees are due at the time of service, when applicable. Please present your insurance card(s) and driver's license to the office staff with this completed form. We will copy them for your records and return them to you immediately.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Virginia Cardiovascular Group** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If "other health insurance: is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

FINANCIAL POLICY: We are dedicated to providing you with the best possible care and services available. We regard your understanding of our financial policies as an essential element of your care treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless either you or your health care coverage carrier has made other arrangements in advance, full payment is due at the time of service

YOUR INSURANCE: We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. If your insurance requires a referral to a specialist, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current**. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**
I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.
Minor Patients: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

Cancelation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $25 charge.

RETURNED CHECKS: It is our office policy to charge a fee of **$35.00 for any returned checks.**

COMPLETION OF FORMS: We will be happy to complete attending physician's statement, insurance and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms**. Please allow 10-14 business days for completion of forms.**

DELIQUINT ACCOUNTS: We reserve the right to add reasonable interest and collection charges to any account over 45 days past due. Interest of 1.5% would be added on (for each month) if the bill is not paid within 45 days.

DECLARATION: I have read and I understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
SIGNATURE & NAME of patient / insured / guarantor / responsible party DATE

_____ _____
SIGNATURE & NAME of Co-Responsible Party DATE

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Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for **Virginia Cardiovascular Group** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (HCO). (The Notice of Privacy Practices provided by **Virginia Cardiovascular Group** described such uses and disclosures more completely). I too have the right to review the notice of Privacy Practices prior to signing this consent.

With this consent, **Virginia Cardiovascular Group** may call (phone #)_____ or other alternative location and leave a message on voice mail, email or in person in reference to any items that assist the proactive in carrying out HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, results and labs.

With this consent, **Virginia Cardiovascular Group** may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that **Virginia Cardiovascular Group** restrict how it uses or disclose to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Virginia Cardiovascular Group** to use and disclose my PHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it **Virginia Cardiovascular Group** may decline to provide treatment to me.

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Guardian, if applicable Date

_____
Relationship to Patient

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Patient Medical Information

Name _____ Age _____ Height _____ Weight_____

Referred By_____ Family Physician _____

Race (Circle one) Asian / Black / Native American / Native Hawaiian / Caucasian / 2 or More Races

Ethnicity (Circle one) Hispanic / Latino / Not Hispanic and Not Latino

Preferred Language _____

Reason for visit today _____

Current Medications:	**Start Date**	**Dosage**	**Frequency**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:	**Start Date**	**Type of Reaction**	**Mild/Moderate/Severe**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Risk Factors (Please circle appropriate/Provide year of onset and any details):
Chemical Exposure / Alcohol abuse / Substance Abuse / Other: _____

Advanced Directives (Please specify): _____

Occupation: Attorney / Clerical Worker / Computer Technician /Hair Stylist / Homemaker / Manual Laborer / Nurse / Painter / Physician / Retired / Sales / Student / Teacher / Works with Chemicals / Other
_____

Have you ever had problems with anesthesia? ____Yes ____No

Any Non – Surgical Hospitalizations? Yes /No -? _____

Surgical History: (Please circle appropriate and provide Details):

Neurological Surgery / Ear Surgery / Eye Surgery / ENT Surgery / Respiratory Surgery / Cardiovascular Surgery / GI Surgery / Renal / Urological Surgery / Orthopedic Surgery / Other (general Surgery)

_____

Have You Had any Screening Tests (General Tests / Psychiatric Tests / Other Tests)?

If so, When? _____

Prior Treatment History: (Please circle and provide details below)
Musculoskeletal Treatments/ Neurological Treatments / Psychiatric Treatments / Other Treatments: _____

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Non-Neurological Past Medical History (Please circle appropriate/Provide year of onset and any details):
Allergies / Immuno-Deficiency/ Cancer / Heme/lymph Disorder / Cholesterol/lipids disorder / Diabetes / Thyroid Disease / Endocrine or Metabolic Disorder / Eye Disorder / Ear Disorder / asthma / Emphysema / respiratory Disorder / Hypertension/ Cardiovascular Disorder / Liver Disease / GI Disorder / Kidney Disease / GU (F) disorder / GU (M) disorder / musculoskeletal disorder/ skin disease / Other

Family History: (Please State Medical History and Indicate Relationship)

_____

Injury Details:
Please indicate below History of Any Injury/Trauma including date of injury, Location or Type of Injury and the circumstance that caused the injury:

_____

Other Social history: _____

Smoking Status: Please Circle
Current Every Day Smoker / Current Some Day Smoker / Heavy Tobacco Smoker / Former Smoker / Never Smoker

Tobacco Use: Please check
[ ] History of Use [ ] Used Tobacco in Last 30 Days [ ] Used Smokeless Tobacco in Last 30 Days

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature Date