PERSONAL INFORMATION UPDATE

Patient Initials:

Name:	
Mailing Address:	
Home Phone: Cell Phone: Work Phone:	⇦ Please circle PRIMARY contact number
Email:	* Look for email invite to our Relay Health Patient Portal *
Communication Preference: Preferred Language:	- Email/Patient Portal, Printed/Mailed, Phone - English, Spanish, Other _____
Date of Birth: Gender:	
Race: Ethnicity:	White/Caucasian, Black/Afr Amer, Asian, Amer Ind or Alaska Nat, Native Hawaiian, Pacific Islander, Other Race - Hispanic, Non-Hispanic
Primary Care: Cardiologist:	

HIPAA Information:

1. I hereby authorize my insurance company, I have provided the information, to pay benefits to Winchester Cardiology and Vascular Medicine, PC for services rendered. I agree to accept full financial responsibility as a patient for receiving medical services.

2. By signing this consent form, I am granting written consent to Winchester Cardiology and Vascular Medicine, PC to provide medical treatment. I understand that I have the right to inquire to the cost and reason for services ordered by my physician. Winchester Cardiology and Vascular Medicine has the authority to disclose my Protected Health Information (PHI) for the purposes of treatment, payment and healthcare operations. Any other individual request for my PHI other than "incidental", will require my signature releasing these records requested. (Ex: life insurance applications, disability benefits, etc.)

3. Winchester Cardiology and Vascular Medicine reserves the right to purge records after 7 years of inactivity.

4. I have the right, at any time, to revoke this consent in writing. Direct to Management Staff.

5. After payment is received from your insurance company, any outstanding balance will be transferred to my personal responsibility. At that time, I will be asked to settle my account. Failure to pay in a timely manner will result in my account being forwarded to a collection agency. Should my account proceed to collections, I will be responsible for any cost charged to Winchester Cardiology and Vascular Medicine by the collection agency. I further agree to pay any and all collection fees incurred and any legal expenses, including but not limited to Collection Agency and attorney fees, all court related fees, filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.

6. I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

7. Please list any persons you would like to authorize to have access to your billing, appointment or health information such as spouse, caregiver or family member.

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____ **Date:** _____