# Pediatric Cardiology Patient Registration

## Patient Information

| Child's Name: First Name – M I – Last Name | Nick Name | Birth Date | Sex | AGE |
|---|---|---|---|---|
| | | | [] M [] F | |

**Mother** (❒ Birth ❒Stepmother / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Mother?* **Yes / No**

| Mother's Full Name (First M. Last) | | Profession | | Date of Birth |
|---|---|---|---|---|
| Home Address | | City | State | Zip |
| Mother's Employer Name & Address | | | Work Phone Number ( ) | |
| Home Phone Number | Cell Phone Number | | Mother's Home E-mail | |

**Father** (❒ Birth ❒Stepfather / ❒Married ❒Unmarried ❒Divorced ❒Widowed) *If divorced, does child reside with Father?* **Yes / No**

| Father's Full Name (First M. Last) | | Profession | | Date of Birth |
|---|---|---|---|---|
| Home Address | | City | State | Zip |
| Father's Employer Name & Address | | | Work Phone Number ( ) | |
| Home Phone Number | Cell Phone Number | | Father's Home E-mail | |

## Referring Physician – (Primary Care Physician) Contact Info

| Physician Name:<br><br>Reason for Today's Visit: | |
|---|---|

## Primary Insurance Information

| Policy Holder's Name (As it appears on card) | | | Social Security Number of Subscriber | |
|---|---|---|---|---|
| Primary Insurance Company / Health Plan Name | | Sex of Policy Holder [] M [] F | Policy Holder Date of Birth | Effective Date |
| Policy Holder's Employer | | Employer Health Plan? [] Yes [] No | Identification/Policy Number | |
| Insurance Address | | Insurance Network | | Group Number |
| City | State | Zip | Insurance Phone Number for Eligibility/Verification ( ) | |

## Secondary Insurance Information

| Policy Holder's Name (As it appears on card) | | | Social Security Number of Subscriber | |
|---|---|---|---|---|
| Primary Insurance Company / Health Plan Name | | Sex of Policy Holder [] M [] F | Policy Holder Date of Birth | Effective Date |
| Policy Holder's Employer | | Employer Health Plan? [] Yes [] No | Identification/Policy Number | |
| Insurance Address | | Insurance Network | | Group Number |
| City | State | Zip | Insurance Phone Number for Eligibility/Verification ( ) | |

# Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Pediatric Cardiology of Maryland to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing. Protected Health Information may be released to the following individuals:

_____ _____

_____ _____

# Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Pediatric Cardiology of Maryland Notice of Privacy Practices, 2014 Revision. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

# Financial Policies Acknowledgment

I acknowledge that I have received, or had the opportunity to receive a copy of the Financial Policies of Pediatric Cardiology of Maryland, LLC while in the office, or on the Pediatric Cardiology of Maryland website (www.PediatricCardiologyMD.com). I understand that the practice has the right to change its Financial Policies, and that I may contact the practice at any time to obtain a current copy of the Financial Policies.

# Financial Policies Agreement

Once the patient responsibility portion of your account is determined, Pediatric Cardiology of Maryland will issue financial statements through the United States Postal Service as well as a courtesy phone call from our billing department. Patient payments are accepted over the phone with credit card or digital checks, through our online portal, or by mail. If after 60 days no payment has been received, you will be liable for a 30% collection/attorney fee plus a 2.99% processing fee for any electronic payments.

**Patient Name** _____

**Responsible Party Name** _____ **Relationship** _____

**Responsible Party Signature**_____ **Date** _____