



Office Use Only: Ins Card <input type="checkbox"/> DL <input type="checkbox"/> HIPAA <input type="checkbox"/> NP <input type="checkbox"/>	
Doctor/Location _____	Patient Number _____

PLEASE PRINT ---- PLEASE PRESENT INSURANCE CARD(S) AND DRIVER'S LICENSE TO RECEPTIONIST

Patient Information

Last Name _____ First Name _____ Middle Initial _____
 Social Security # _____ Date of Birth _____ Male Female
 Address _____ City _____ State _____ Zip Code _____
 Email Address _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Employer _____ Address _____ City _____ State _____ Zip _____

Marital Status: Married Single Divorced Widow Separated **Student:** Full Time Part Time
Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Decline
Primary Language: English Spanish Other Decline **Ethnicity:** Hispanic or Latino Non-Hispanic or Latino Decline

Spouse/Guarantor Information

Last Name _____ First Name _____ Middle Initial _____
 Social Security # _____ Relationship _____ Date of Birth _____ Male Female
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Employer _____ Address _____ City _____ State _____ Zip _____

Insurance Information

Primary Insurance Company _____ Co-pay _____
 Policy # _____ Group # _____ Effective Date _____
 Name of Insured _____ Relationship _____ Date of Birth _____
 Secondary Insurance Company _____ Co-pay _____
 Policy # _____ Group # _____ Effective Date _____
 Name of Insured _____ Relationship _____ Date of Birth _____
 Does your Insurance require a referral? No Yes – If yes, referral number _____

Emergency Contact Information – Please list someone NOT living in the same household.

Name _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Address _____ City _____ State _____ Zip Code _____

Primary Care Physician

Referred By: Physician Self Friend/Relative Yellow Pages Other

 It is understood that no oral or written contract exists which designates by name or description the individuals who will treat the patient. The individual who treats the patient may vary from time to time due to emergencies or the location at which the patient wishes to be seen. We will make every effort for you to be seen by the physician of your choice, but appreciate your understanding when it is not possible.

I hereby authorize Cardiology Associates to administer treatment and perform necessary procedures in diagnosing and/or treating my condition. Also, I hereby authorize the release of any medical information necessary for the processing of insurance. This assignment will remain in effect until revoked by me in writing. This assignment is to be considered as valid as an original.

Signature of Patient: _____ Date: _____

As a service to our patients, we will assist in filing insurance and obtaining reimbursement. However, all incurred charges remain the responsibility of the patient. In order to service your account or collect monies owed, our office and/or its agents may contact you using telephone numbers associated with your account, including wireless telephone numbers which could result in charges to you. Phone contact may include pre-recorded/artificial voice messages and/or automatic dialing devices. We may also contact you via text messages or e-mails.

I agree to these methods of communication being used to contact me regarding my account. I agree to pay all collection agency fees (up to 33.33%), in addition to necessary attorney fees and court costs. I waive now and forever my right of exemption under the laws of the constitution of the state of Alabama and any other state.

Signature of Patient: _____ Date: _____