David Henderson, MD
Nathaniel Valin, MD
Dinesh Arab, MD
Barton Sickinger, DO
Rene Celis, MD
Marvin Lu, MD
Garly Saint Croix, MD
David Bamberger, PA
Melissa Clegg, NP
Mary Wittnebert, NP
Christy Lent, NP

Cardiology PHYSICIANS

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **DOB:**_____ **Sex:**_____

Address:_____

Unit/Apt#_____ **City:**_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____ **Email:**_____

EMERGENCY/HIPAA CONTACT INFORMATION

In order to help us stay within the guidelines of HIPAA, please list below any person/persons that you authorize us to disclose information regarding your Protected Health Information.

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

INSURANCE INFORMATION

Primary Insurance: _____ **ID#:**_____

Secondary Insurance: _____ **ID#:**_____

1. **CONSENT:** I consent to the use or disclosure of my protected health information by Cardiology Physicians Memorial, LLC to diagnose or provide treatment to me, obtain payment for my healthcare bills, or to conduct the healthcare operations of Cardiology Physicians Memorial, LLC. I understand that the diagnosis of treatment of me by Cardiology Physicians Memorial LLC may be conditioned upon my consent as evidenced by my signature on the document.
2. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY BENEFITS:** I understand that Cardiologhy Physicians Memorial, LLC Notice of Privacy describes the types of uses and disclosures of my protected health information that may occur in the treatment payment of my bills or in the performance of the healthcare operations of Cardiology Physicians Memorial, LLC. By signing this document I acknowledge that a copy of the Cardiology Physicians Memorial LLC Notice of Privacy Practice will be provided to me upon request.
3. **CANCELLATION POLICY:** If you are not able to make your appointment please notify our office at least one day before your appointment. We reserve the right to charge a fee for appointments canceled with less than a 24-hour notice.
4. **PAYMENT INFORMATION:** Copay/Co-Insurance are due at the time of your visit. Payment is due in full at the time of service for all non-par insurance plans. All returned checks will be charged a fee of $35.00 in addition to any bank fees.
5. **COPYING:** We will charge you a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill your request. Our standard fee for copying is currently $1.00 per page up to 25 pages then $.25 per each additional page.

Patient or Representative Signature:_____ **Date:** _____

103 Memorial Medical Parkway, Ste. 200, Daytona Beach, FL, 32117
Phone: 386-615-1521 Fax: 386-671-0694
600 Palmetto Street, Ste. 1, New Smyrna Beach, FL 32168
Phone: 386-615-1521 Fax: 386-410-2087

CARDIOLOGY PHYSICIANS MEMORIAL, LLC

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Patient Financial Policy

Thank you for choosing Cardiology Physicians Memorial, PA as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for service is a part of that relationship. Please ask if you have questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (address, name, insurance information, etc.). Cardiology Physicians, PA does not discriminate against any person on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, religion or creed in admission, treatment, or participation in its programs services and activities, or in employment, or on the basis of sex in its health programs and activities.

CO-PAYS

All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post dated checks will be accepted.

INSURANCE CLAIMS

Insurance is a contract between you and your Insurance Company. We will bill your Primary Insurance Company as a courtesy to you. In order to properly bill your Insurance Company we require that you disclose all insurance information including Primary and Secondary, as well as, any change of insurance information. FAILURE to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your service performed at our office, you may be responsible for the complete balance of the non-payable services. If we are **OUT OF NETWORK** with your insurance company and your insurance pays your directly, you are responsible for payment and agree to forward the payment to us immediately.

MISSED APPOINTMENTS

We require a 24-hour notice of appointment cancellations. Appointments missed and are not previously canceled may be charged a missed appointment fee.

RETURNED CHECKS

In accordance with state law a fee of $35.00 for ALL returned checks will be applied to your account in addition to the insufficient funds amount. You will be placed on a CASH ONLY basis following any returned check. Copay(s) is/are due at the time of service. Payment is due in full at time of service for ALL non-par insurance plans.

OUTSTANDING BALANCE POLICY

It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a phone call will be made to try to make payment arrangements. If no resolution can be made the account will be sent to a collection agency, or attorney and possible discharge from the practice. In the event an account is turned over for collections the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements and receiving treatment, you are ultimately responsible for payment of the service.

I have read the above financial policy and understand my financial responsibility to my healthcare provider.

_____ _____

Signature of patient or personal representative **Date**

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Patient Name: _____ DOB: _____

Address: _____

MEDICAL RECORDS RELEASE - OBTAINING RECORDS FROM

Name of Physician or Hospital: _____

Address: _____

Phone #: _____ Fax #: _____

I authorize my physician and/or the practices' administrative and clinical staff to use and/or disclose Health Information about me as described below:

1. Description of the information to be used or disclosed (Check ALL That Apply):

_____ Medical information relating to a specific medical condition _____

_____ Laboratory, radiological or other test results (describe condition)_____

_____ the patient's entire medical records related to Cardiology Physicians

_____ Other: _____

2. I understand this Protected Health Information is being used or disclosed at the request of the patient.
3. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy Officer at Cardiology Physicians Memorial, LLC. I understand that a revocation is not effective to the extent that my physician has relied on this authorization prior to receiving notice of revocation or my authorization was obtained as a condition or obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that if the person or entity that receives the Health Information described above is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations, the information described above may be re-disclosed by the recipient and will no longer be protected by the privacy regulations.
5. I hereby authorize the release of my medical records to the requesting physician. This information is to include alcohol, drugs, sickle cell anemia, and HIV. I understand this release will remain in effect until it has been revoked by the patient in writing.

_____ _____

Signature of patient or personal representative **Date**

_____ _____

Printed name of patient or personal representative **Relationship to patient**

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