COLUMBUS CARDIOLOGY ASSOCIATES, P.C.
Caring for the Heart from the Heart

PATIENT REGISTRATION FORM

PLEASE INDICATE IF YOU HAVE SEEN ANY OF THE PHYSICIANS IN THE PRACTICE BEFORE? YES/NO

Michael Ibe, M.D. _____ Mahesh Patel, M.D. _____
Alonzo Jones, M.D. _____ Hiren Shah, M.D. _____
George Miller, M.D. _____

Name: _____
First Middle Initial Last
Social Security: _____ Date of Birth: _____

Age: _____ Sex: _____ Marital Status: _____

Home Address: _____
Street City State Zip
Home Phone: ( ) _____ Work Phone:( )_____

Mobile Phone: ( ) _____ Day Time #:( ) _____

Ethnicity: African American Asian Caucasian Hispanic Indian Other:_____

Language: English Spanish Other: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____Subscriber Name: _____
Primary Insurance #: _____ Group #: _____
Secondary Insurance: _____Subscriber Name: _____
Secondary Insurance #: _____ Group #: _____
Tertiary Insurance: _____Subscriber Name: _____
Tertiary Insurance #: _____ Group #: _____

Email: _____
Emergency Contact: _____Relationship: _____Phone #: _____

Assignment of Benefits

The above information is true to the best of my knowledge. I hereby consent to and authorize the provision of all treatment and performance of all examinations which, may be considered necessary or advisable for my diagnosis and/or treatment while I am a patient of CCA, P.C. I understand that on occasion, the services that I receive may be performed by a Certified Nurse Practitioner under the supervision of a licensed physician. To provide continuity of care, I authorize the release of medical information to other physicians. I authorize my insurance to release any benefits to be paid directly to CCA, P.C. I authorize CCA, P.C. to release to the insurance company information required to process my claims. I understand that I alone am responsible for charges resulting from my treatment and care.

Patient/Guardian Signature: **Date:**

_____ _____

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lternative Communication Release Form

I authorize Columbus Cardiology Associates, P.C. in regard to my protected health information:

_____To speak with anyone listed on the Right to Share Information list below and to pick up my prescriptions
_____To speak only with me.

Right to Share Information with Family and Friends

Columbus Cardiology Associates, P.C. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy Practices.
In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals that we are authorized to release information to.

	Allowed to Pick up Prescriptions	
_____	Yes	No
Print Name/Relationship		
_____	Yes	No
Print Name/Relationship		
_____	Yes	No
Print Name/Relationship		
_____	Yes	No
Print Name/Relationship		

_____ _____
Patient Name (printed) **Date of Birth**

_____ _____
Signature of Patient/Guardian **Date**

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ACKNOWLEDGEMENT of RECEIPT of Joint Notice of Privacy Practices

By signing this form, I acknowledge receipt of the Columbus Cardiology Associates, P.C. *Joint Notice of Privacy Practices:*

_____ _____
Signature Patient, Parent or Personal Representative *Date*

If other than the patient, please specify relationship:

_____

FOR CCA, P.C. USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If unable to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement and the reason acknowledgement was not obtained*:*

___ Patient refused to sign ___ Patient unable to sign ___ Other: _____

_____ _____ _____
CCA P.C. Staff Member Signature Print Name Date

COLUMBUS CARDIOLOGY ASSOCIATES, P.C.
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Financial Policy

Our goal is to provide our patients with the finest medical care available at a cost that is both fair and reasonable. Understanding of our financial policy is essential.

Please review and sign below:

- Payment is due at time of service.
- Insurance will be filed with valid insurance information or a valid insurance card.
- Patients without insurance may contact our Financial Counselor prior to your visit to make payment and/or payment arrangements. A minimum of 25% of New Patients visit expenses are expected prior to service.
- All co-payments, co-insurance, and deductible amounts are due at the time of service. We accept cash, check, Visa, MasterCard, American Express, and Discover.
- Charges not paid by you or your insurance company within 90 days will become immediately due. Unpaid balances greater than 90 days are subject to collection procedures.
- Durable medical equipment (DME) and supply costs are provided through a third-party vendor. Payment For DME must be arranged with the third-party vendor prior to or at the time of their service.
- Worker's Compensation for on-the-job injuries will be accepted if pre-authorized by your employer or worker's compensation insurance carrier prior to your first visit.
- Automobile/liability insurance for accidents/injuries will be accepted with appropriate authorizations from insurance plans. Health insurance must also be provided with automobile insurance.
- A $35.00 service charge will be applied to your account for any returned check. If a check has been returned, we will only accept cash or credit card.

The undersigned agrees to all terms and conditions contained herein.

Print Patient's Name: _____

Patient/Legal Guardian's Signature: _____

Date: _____

COLUMBUS CARDIOLOGY ASSOCIATES, P.C.
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Office Policies

Phone Calls and Emergencies:
We receive telephone calls from 7:30am to 5:30pm Monday through Thursday and Friday 8:00am – 12:00pm. If the physician or staff member is not available at the time of your call, You may leave a message to be directed to the appropriate employee. Telephone calls will be returned within 48 - 72 hours (2-3 business days). If you have an emergency, please call 911 or proceed to the nearest emergency room.

Prescription refills:
Please bring any medications you are currently taking with you for your appointment for review by your physician. Prescriptions will be refilled at the time of your office visit. You must notify us at least one (1) week prior to running out of your medication. After hours or weekend requests will be processed within two business days.

Demographic Information:
At each visit, you will be requested to verify and or confirm your address, telephone numbers, birth date, social security number, and current insurance information, including copies of your insurance card and a picture ID for proper identification.

Form Completion Fees:
Requests for completion of forms/documents by our staff and/or physicians will be returned within thirty (30) days. Payment is required at the time of your request. You will be notified via telephone when your documents are completed and ready for pick up.

Medical Records:
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to access your personal health information in your medical record upon written request. Another physician may also request a copy of your medical record, which will be provided at no cost to your or the physician. Third party medical record requests will incur a fee. Please allow up to thirty (30) days to process your request.

Patient Statements Policy:
Payments are due at time of service. You will receive a statement for any outstanding balances. If you have insurance, we will file a claim for services provided, any balance after insurance is your responsibility. Payment is due upon receipt of your statement.

If you have any questions or concerns about any of the above policies, please feel free to contact our office at 706-323-5552.

Patient Name: _____Date of Birth: _____

Chief Complaint: _____ Referring Physician: _____

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Past Medical History

_____ Coronary Heart Disease
_____ Palpitation (Rapid Heartbeat or Fluttering)
_____ Hypertension (High Blood Pressure)
_____ Hyperlipidemia (High Cholesterol)
_____ PVD (Peripheral Vascular Disease) Claudication
_____ Asthma/Bronchitis
_____ Dizziness/Syncope
_____ Smoking
_____ Alcohol Consumption

_____ Chest Pain
_____ Anxiety
_____ Depression
_____ CVA (Stroke)
_____ kidney disease
_____ Thyroid Disease
_____ TB, Hepatitis, HIV/AIDS
_____ Drug Use
_____ Diabetes

Women Only
Last Menstrual Period _____ Age of Menopause _____

PAST HOSPITALIZATION/SURGERY/INTERVENTIONS/MAJOR ILLNESSES

DATE	REASON	DATE	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies to medications, IV dye, shellfish, etc. _____
_____

FAMILY MEDICAL HISTORY

Disease	**Relationship/Age of Onset**
Heart Disease	_____
High Blood Pressure	_____
Stroke	_____
Peripheral Vascular Disease	_____
Kidney Disorders	_____
Thyroid Disorder	_____
Diabetes	_____
Bleeding Disorders	_____

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Cancellation Policy

We have developed an appointment system that allocates the appropriate amount of time for each patient to provide quality care to all our patients for follow-up appointments, diagnostic tests, and procedures. To avoid fee assessment, patients should contact our office at 706-323-5552 no later than 24 hours prior to their scheduled appointment. This will allow time to schedule awaiting patients in need of an appointment.

Fees for failure to cancel or reschedule your appointment within 24 hours of your appointment time:

- $25 fee for follow-up appointments
- $50 fee for diagnostic testing (Echo, Stress Test, Vascular)
- $75 fee for procedures (LHC, RHC, Aortogram, TEE, Ablation)

Please note:

- the fee is charged to you and not your insurance company
- the fee is due prior to your next appointment
- the fee may be paid via telephone

We make reminder calls and text messages to your cell phone and email. This allows time for you to contact us prior to 24 hours, if needed. We understand there may be emergencies that prevent you from keeping your scheduled appointment. If you should experience an abnormal circumstance, please contact us directly at 706-323-5552 during regular business hours. Monday through Thursday 7:30am – 5:30pm and Friday 8:00am – 12:00pm.

Failure to notify us of a cancellation within 24 hours for three consecutive appointments will result in review of your appointment history and could lead to dismissal from our practice.

_____ _____

Patient/Legal Guardian Signature Date