ADVANCED CARDIOVASCULAR CONSULTANTS, SC (ACVC)
PATIENT REGISTRATION

Last Name:	First Name:	Middle:

Street Address:		
City:	State:	Zip:

Gender:	Date of Birth:	SSN:
Marital Status:	Spouse:	
Primary Phone:	Other Phone:	Work:

Primary Care Physician:	Address / Phone:
Referring Physician:	

Emergency Contact:	Relationship:
Emergency Contact Phone:	

Pharmacy Name And Address: →

PLEASE PRESENT INSURANCE INFORMATION TO RECEPTIONIST AT EACH APPOINTMENT

Primary Insurance:	
Group No:	Copay:
Is Coverage Through An Employer?: Yes No	Class:
Name Of Insured:	Employer Of Insured:
Patient Relationship To Insured:	Insured Date Of Birth:

Secondary Insurance:	
Group No:	
Is Coverage Through An Employer?: Yes No	Class:
Name Of Insured:	Employer Of Insured:
Patient Relationship To Insured:	Insured Date Of Birth:

 Initial Here →_____

ADVANCED CARDIOVASCULAR CONSULTANTS, SC (ACVC)
PATIENT REGISTRATION (continued from page 1)

☐ I have received or received a copy of the patient policies dated January 1, 2020.

☐ I have declined a copy of the patient policies and understand the policies apply to me.

By signing below, I acknowledge that I have read and understand this document and that the demographic information is correct or the appropriate changes have been made. I understand that I may be liable for Charges that result from any inaccurate information provided.

Patient
Signature: →_____ Date: →_____

<u>MEDICARE</u> PATIENTS, PLEASE CHECK THE CORRECT RESPONSE BELOW

1. Do you/your spouse work for a company that provides you with health insurance? If retired, please indicate date retired	Yes	No
2. Is this illness or injury the result of an automobile accident or other injury?	Yes	No
3. Is this illness/injury the result of an accident or illness that occurred at work?	Yes	No
4. Has treatment for this accident/illness been authorized by the Veterans Administration?	Yes	No
5. Are you entitled to any benefits under the Federal Black Lung Program?	Yes	No

Patient
Signature: →_____ Date: →_____

ADVANCED CARDIOVASCULAR CONSULTANTS, SC (ACVC)
PATIENT POLICIES (January 1, 2020)

Allergy and Medication Update: I understand it is the responsibility of the patient to inform the rendering provider of allergies and medication changes at each appointment.

Follow Up Appointments: I understand it is the responsibility of the Patient to discuss with the provider when the patient is to return for a follow up appointment. The patient is required to make and keep an appointment that is within the providers follow up time frame.

Medical Records and Charges: I hereby authorize Advanced CardioVascular Consultants,SC to disclose to any person or corporation which is or may be liable under contract or agreement to Advanced CardioVascular Consultants, SC or to me or my employer for all or part of the charges of Advanced CardioVascular Consultants, SC (including medical service companies, welfare funds or employer) all or any part of its medical records concerning me with respect to any illness or injury, medical history consultation, prescription or treatment, including x-rays and images.

Advanced Directive (Living Will): I understand that it is the responsibility of the patient to inform the rendering provider of a Living Will and provide a copy of such to Advanced CardioVascular Consultants, SC. I understand it is the responsibility of the patient to provide an updated Living Will To Advanced CardioVascular Consultants if changes have been made.

Insurance and Payments: I hereby authorize payment of any medical benefits directly to Advanced CardioVascular Consultants, SC that would otherwise have been payable to me. I understand that uninsured charges or amounts deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me.

Prescription Refills: I understand that medication refills must be obtained by calling the refill request to the pharmacy that previously dispensed the medication. I understand that I must allow 2 complete business days to allow the refill request to be processed by ACVC.

Phone: By providing ACVC with my wireless/cell phone or land line phone number, I am hereby granting ACVC, their agents, or independent contractors, consent to make place call to my wireless/cell phone or land line.

Email: By providing ACVC with my email address, I am hereby granting ACVC, their agents, or independent contractors, consent to be sent Email I understand that I may be contacted by Advanced CardioVascular Consultants, SC, at the discretion of the provider or office staff(s)

Pre-authorization / Prior Authorization: Advanced CardioVascular Consultants will submit one single request for pre-authorization or prior authorization of a medication, or procedure, or test, if required and requested by the patient or rendering facility. Should the authorization be denied, it is then the responsibility of the patient to contact their insurance and obtain a pre-authorization or prior authorization approval. Advanced CardioVascular Consultants cannot be responsible for charges incurred for medication, or procedures, or testing, performed under any circumstances.

Behavior and Communication: ACVC has a Zero-Tolerance policy against behavior that threatens the safety or well-being of others. Threatening behavior or language in person or over the phone are grounds for dismissal from the practice. This includes but is not limited to verbal threats or derogatory statements, throwing objects or tampering with property, possession and use of alcohol or illegal substances while on premises, knowingly providing staff with false or misleading information, excessive or repetitive noise, physical acts of violence or aggression, sexual comments or offensive gestures or theft.