MRN:

## Patient Registration

Patient Name _____ Patient's Social Security Number _____

Street Address _____ City _____ Zip _____

Date of Birth _____ Marital Status S M W SEP O Sex M F

Telephone #: Home _____ Work _____ Cell _____

Email _____ Race _____ Ethnicity _____

Pharmacy Name _____ Street: _____ City: _____

Mail Order Pharmacy _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Tel# _____ Relationship _____

Sent by Doctor _____ Family Doctor _____

## Patient Employer Information

Employer Name _____ Occupation _____

## Insurance Information

Primary Insurance _____ Effective Date _____

Subscriber Name _____ Relationship to patient _____ DOB _____

ID# _____ Group# _____ Tel# _____

Secondary Insurance _____ Effective Date _____

Subscriber Name _____ Relationship to patient _____ DOB _____

ID# _____ Group# _____ Tel# _____

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order
I request that payments of authorized benefits from Medicare/insurance Company be made directly to my provider
I authorize my provider to release any medical information about me to HCFA/my insurance and its agents, any information needed to determine these benefits or the benefits payable to related services
I authorize the use of this authorization for any of my insurance claims
I understand that I am responsible for any amount not covered by my insurance company(s)
I certify the information that I have reported with regards to my insurance coverage is correct
I permit a copy of this authorization to be used in place of its original
This authorization may be retrieved by either me or my insurance company at any time in writing
I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider

Patient Signature _____ Date _____

Parent Signature _____ Date _____

GEORGE NAHHAS, MD, FACC
JOSEPH CHATTAHI, MD, FACC
PETER MANCINI, MD, FACC

# Financial Policy

1. All copays are due at the time of service.
2. Staff may request a copy of your insurance card at every visit to verify coverage and ensure that no changes have been made. This is a request from insurance companies.
3. As per Federal guidelines, there will be a charge for all services performed by the physician in the hospital and in the office. This may include services interpreted by the physician not in your presence. By allowing the physician or staff to care for you, you are agreeing to pay for the services rendered and are responsible for full payment. Any appeal must be made at the time of service.
4. Federal legislation prohibits the physician from waiving any copay, deductible, or other balances that the patient may incur. This includes not billing for services at all.
5. If you do not have insurance we are still required to charge for all services provided at, or above, the published current fiscal year Medicare fee schedule. We have a private pay fee schedule for all services provided at this office.
6. Please do not ask our physician to waive your copay or deductible. The physician could incur severe penalties and lose his participation privileges for government funded programs as well as commercial insurance companies.
7. If you are unable to pay your bill in full, please contact our billing department for payment options. We will be happy to assist you.
8. Most HMOs require a referral for each and every service. It is your responsibility to obtain a referral from your Primary Care Physician (PCP) for each service performed as applicable.
9. It is your responsibility to understand the guidelines of your insurance policy, including any applicable copays and/or deductibles. You will be responsible for all non-covered services.
10. As a courtesy, we will process and file medical claims to your insurance company on your behalf. From time to time we may request your assistance in processing these claims.
11. Acceptable forms of payment include Cash, Check, Visa, MasterCard, and American Express. There will be a $25.00 fee for all returned checks.
12. There is a fee for the completion of all medical records releases and disability forms requested by the patient.
13. Payments are always applied to the oldest outstanding balance. Please retain receipts for your records.
14. We request 48 hour notice for appointment cancellations. We reserve the right to charge for time and medical supplies lost for "no shows". This is not covered by insurance and will be the patient's responsibility.
    *$100 cancellation fee will be applied for cancellation of varicose vein treatments without 48 hour advance notice
    *$150 cancellation fee will be applied for cancellation of nuclear medicine services without 48 hour advance notice
15. We reserve the right to charge interest on balances outstanding after 90 days, at the maximum allowable interest rate under the laws of the State of Michigan, and to utilize all available legal mechanisms for collection of outstanding bills.
16. We reserve the right to terminate our physician-patient relationship in the event of your failure or refusal to comply with this financial policy and pay outstanding balances owed.

*FEES AND POLICIES ARE SUBJECT TO CHANGE*

## ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read this office's financial policy. I understand and agree to the terms as they have been set forth. I hereby authorize my insurance benefits to be paid directly to my physician, realizing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient signature_____ Date_____

Patient Name (Printed) _____

GEORGE NAHHAS, MD, FACC
JOSEPH CHATTAHI, MD, FACC
PETER MANCINI, MD, FACC

## Permission to Communicate my Health Information Electronically

Our office is pleased to inform that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

**PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.**

_____ **YES,** I want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have been informed about information that will be communicated and have had the opportunity to ask any questions that about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking the NO section and entering a revised date. If I withdraw permission any information in my electronic medication record will not be accessible by the health information exchange. At that point my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

____ **NO,** I do not [or no longer] want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care, especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

_____
Print First Name, Last Name, DOB

_____ _____
Signature of Patient or Representative Date

# NOTICE

Due to the constant changes in insurance, it is no longer possible to interpret each individual's policy. Although we try to stay aware of the changes, **It is not possible.**

## IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Please do not get angry at us if your insurance does not cover our services. All insurance policies have exclusions and most policies have deductible and co-pays which can change yearly.

Please remember that your insurance policy is between you and your insurance company and NOT between the insurance company and the Doctor.

Patient Name(Printed) _____ Date of Birth _____

Signature of Patient _____ Date _____

# HIPAA Privacy Rule of Patient Authorization Agreement

## Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

# Privacy Rule of Patient Consent Agreement

## Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness .....

X

Printed Name of Patient or Legal Representative Witness .....

Date: .....