

Dr. S. Nayyar Shah,  
MD, FACC, FHRS, FRCP

# PATIENT REGISTRATION

## PATIENT INFORMATION

### PATIENT DEMOGRAPHICS

First Name:	Middle:	Last Name:
Date of Birth:	Sex:	Nickname:
Marital: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Last 4 Digits of Social Security Number : XXX-XX-_____	
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:	Preferred Language:	
Preferred Phone Communication: <input type="checkbox"/> Leave a Message with Detailed Information <input type="checkbox"/> Leave a Message with a Call-Back Number Only		
How did you hear about our office?		

### GUARANTOR INFORMATION

First Name:	Last Name:	
Date of Birth:	Relationship to Patient:	
Phone:	Driver's License#:	State:
Address:		
City:	State:	Zip Code:

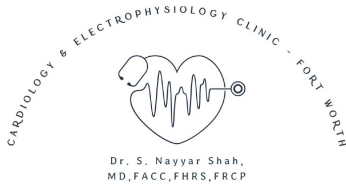
### PATIENT INSURANCE | POLICY HOLDER INFORMATION

First Name:	Last Name:
Date of Birth:	Relationship to Patient:

Please bring the patient's current insurance card and a valid ID, to the front desk when checking in for the appointment. The patient's insurance and ID will be scanned into the system at that time.

### NOTICE OF PRIVACY PRACTICES

I have been given a copy and have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of **Cardiology & Electrophysiology Clinic of Fort Worth**. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.



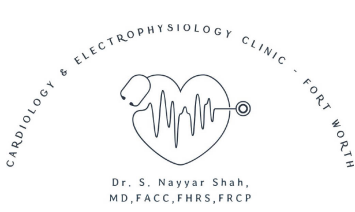
**FINANCIAL POLICIES**

- I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless if they are covered by my insurance company, Medicare and/or supplemental policy.
- Payment is required at the time services are rendered. **Cardiology & Electrophysiology Clinic of Fort Worth** is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is estimated based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.
- Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.
- I understand that a fee may be assessed for returned checks.
- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information.

The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent / Legal Guardian Printed Name:	Relationship:
Signature:	Date:



## PATIENT CONSENTS

### COSENT FOR TREATMENT

I authorize **Cardiology & Electrophysiology Clinic of Fort Worth**, its employees, and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

### CONSENT FOR FILING INSURANCE CLAIMS

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, **Cardiology & Electrophysiology Clinic of Fort Worth** is required to keep my signature on file. I hereby authorize **Cardiology & Electrophysiology Clinic of Fort Worth** to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I also authorize **Cardiology & Electrophysiology Clinic of Fort Worth** to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to **Cardiology & Electrophysiology and Clinic of Fort Worth**. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorney's fees of **Cardiology & Electrophysiology Clinic of Fort Worth**, if any.

### CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize **Cardiology & Electrophysiology Clinic of Fort Worth** and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by **Cardiology & Electrophysiology Clinic of Fort Worth**, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive any and all communications.

**PHI COMMUNICATION PREFERENCES**

I authorize **Cardiology & Electrophysiology Clinic of Fort Worth** to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals, as indicated below. This authorization is voluntary, and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my **protected health information (PHI)** may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

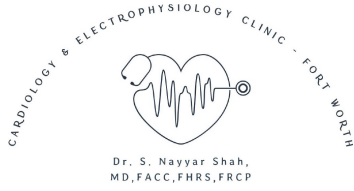
- I elect **not to authorize disclosure** to any individuals at this time
- I elect **to authorize disclosure** to the below list of individuals:

First & Last Name:	Relationship:	Phone:	Medical	Billing
		( )	<input type="checkbox"/>	<input type="checkbox"/>
		( )	<input type="checkbox"/>	<input type="checkbox"/>
		( )	<input type="checkbox"/>	<input type="checkbox"/>

Communication for benign (non-cancerous) test results	Phone
I hereby allow all test results to be put in a voice message on the phone number indicated in the box.	( )

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent / Legal Guardian Printed Name:	Relationship:
Signature:	Date:



# PATIENT REGISTRATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Family/Primary: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ City \_\_\_\_\_ Phone# \_\_\_\_\_

Allergies: Do you have any Allergies to any medications? [ ] Yes [ ] No If Yes, please list below:

*If you have a list we can obtain a copy:*

UPDATED MEDICATIONS			
Name	Dose / Strength	Frequency	Prescribing Physician

Family History: What illnesses have been in your family? List illness and family member affected [ ] None

Past Surgical History: What Operations have you had (for any reason)? [ ] None \_\_\_\_\_

Past Hospitalizations: [ ] None \_\_\_\_\_

New Diagnosis: [ ] None \_\_\_\_\_