East Atlanta Cardiology

************REGISTRAION FORM MUST BE FILLED OUT COMPLETELY************

Name: _____Date:_____

Mailing Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____Work Phone: _____

Cell Phone: _____SSN: _____

Sex: Male Female Date of Birth: _____ Language: English Spanish Other _____

Rac: Black Caucasian Spanish Other_____ Email:_____

Emergency Contact:_____ Phone number: _____
Relationship:_____
****May we discuss your care with the above listed emergency contact? YES or NO**

Primary Insurance_____Policy #:_____
Insured's Name_____Insured's DOB:_____
Insured's SSN:_____Group #:_____
Secondary Insurance_____Policy #:_____
Insured's Name_____Insured's DOB:_____
Insured's SSN:_____Group #:_____

Pharmacy Name:_____Phone #:_____
Address:_____
Referring Physician:_____Phone #:_____

I have completed this form accurately, truthfully and completely. Office Policy: I understand and agree that I will be responsible for any balances not covered by my insurance company. If determined by my insurance company that my physician is not eligible to provide required referrals, I will be responsible for the balance of that visit. I agree that I will be assessed a $40 fee for any appointments that are not canceled within 24 hours prior to my scheduled appointment. In the event that my account balance is 30 days past due, I agree that I will be assessed a monthly $10 fee/rebilling fee. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for a $50.00 service fee, any collection fees (15%), attorney fees, court costs, etc. Any NSF/returned checks will be assessed a $40 fee.

Please note: We must have 48 hours to process your referral and obtain pre-certification from your insurance carrier. If your referral has not been pre-certified by your insurance carrier, you will be held financially responsible for the visit and/or test.

Our office does not provide replies to any emails. Any emails from our office will be reminders for appointments only.

Authorization and release of information. I hereby authorize East Atlanta Cardiology and its affiliates to release information contained in my medical records for the purpose of treatment, payment and operations as follows: 1) to my insurance company(s), their agents, or third party payer, and/or government or social service agencies which may or will pay for any part of my medical care; 2) As mandated by law; 3) To alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or my family for care. I have received and read the HIPPA rules and regulations for East Atlanta Cardiology.

I have received and agree to Office?Financial Policies.

Patient Signature_____Date_____