PATIENT INFORMATION

_____Initial here and sign below if the patient and insurance information have not changed.

Patient Name: **SSN:** **Account#:**

Home Address: **City:** **State:** **Zip:**

☐ I am a resident of a skilled nursing or board and care facility.

Patient's Home#: **Patient's Work#:** **Patient's Cell#:**

Sex: M / F **Patient's Date of Birth:** **Email Address:**

Marital Status: **If married, name of spouse & date of birth:**

Patient's Employer: **Occupation:**

Emergency Contact Name: (Here) **Emergency Contact Phone #:**

Referred By: **Primary Care Physician's:**

Ethnic Classification – Check One: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Declined** ☐ **Unknown**

Race –Check One: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Declined** ☐ **Unknown**

Language - Please Print Preferred Language:

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I authorize **CARDIOVASCULAR CONSULTANTS MEDICAL GROUP** physicians and staff to disclose to and discuss my protected health information with the following person or persons in addition to my other health care providers (e.g. family member, friend)

Name 1._____ 2._____

☐ I prefer no one have access to my health information without my written consent except where allowed by law.

Signature of patient_____

CONSENT FOR TREATMENT

The undersigned hereby authorizes and consents to any cardiac examination, laboratory procedure, and all treatments rendered to me by Cardiovascular Consultants Medical Group.

Date_____ Signature of authorized person_____

FINANCIAL AGREEMENT AND INFORMATION RELEASE

I hereby authorize payment directly to **CARDIOVASCULAR CONSULTANTS MEDICAL GROUP** otherwise payable to me for the services rendered. I understand that I am financially responsible for all copays, deductibles, and noncovered services.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, obtain authorization for medical services and communicate with other treating physicians.

Date_____ Signature of insured/authorized person_____