# San Diego Cardiac Center Medical Group, Inc.
## Patient Registration Form

Date_____ Acct#_____

***PATIENT INFORMATION:** (Use full legal name, no nicknames) ***(*) Required field***

*Last Name_____ *First Name_____ Middle Initial_____

*Address_____*City_____ *State_____ *Zip_____

*Home Ph (_____) _____- _____ *Cell Ph (_____) _____- _____*Social Security _____

*Sex: M☐ F☐ *Date of Birth_____ *Marital Status_____ *E-mail : _____

Emergency Contact _____ Emergency Phone (_____) _____-_____

***Who referred you to us?** _____ *Who is your primary/ family physician? _____

*What is your preferred language ***if not*** English: _____ *Is this a *work-related* injury/illness? No☐ Yes☐

**Work Comp* – Date of Injury: _____ **Work Comp* – Claim No: _____

***RACE & ETHNICITY DATA**: **We are required to request the following information:** ***(You may decline to provide)***

1. **Do you consider yourself to be Hispanic or Latino**? **No** ☐ **Yes** ☐ **Decline to provide** ☐
2. **Which category best describes your race**?

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ **Decline to provide**
☐ Asian ☐ White
☐ Black or African American ☐ Other

***INSURANCE INFORMATION:** Complete **OR** provide a copy of your insurance card(s).

**Primary Insurance: _____ Are you the policy holder? Yes☐ No☐**

**Secondary Insurance: _____**

***If no***: Subscriber Name _____ DOB:_____ Relation to Patient? _____

**FINANCIAL GUARANTOR: Complete only if someone else** is financially responsible for your account.

Last Name_____ First Name_____ Middle Initial_____

Phone (_____) _____- _____ Date of Birth:_____ Relation to Patient_____

**OPTIONAL – PERMISSION TO DISCLOSE PERSONAL INFORMATION**

***I authorize San Diego Cardiac Center to allow access to the following information (check all that apply):***

☐ Personal health record, medical information ☐ Billing information – *billing profile, balance, charges, etc.*

**Access granted to:** Name (Last, First):_____ Ph#: _____Relation: _____

**ASSIGNMENT OF INSURANCE BENEFITS**:

I hereby authorize direct payment of my insurance benefits, including Medicare, MediCal, TRICARE or private insurances, to San Diego Cardiac Center Medical Group (SDCC), Inc. for services rendered to my dependents or me. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit and to inquire with my insurance to verify the providers at SDCC are participating with my health plan. I understand and agree that I will be responsible for any co-pay, deductible or balance due that the San Diego Cardiac Center Medical Group, Inc. is unable to collect from my insurance carrier for whatever reason.

**Patient/Guarantor Signature X** _____ **Date**_____

# San Diego Cardiac Center Medical Group, Inc.

## Patient Consents and Acknowledgements

**CONSENT TO TREAT AND RELEASE INFORMATION:**
I hereby consent and authorize medical services including evaluation, testing and treatment as directed by my San Diego Cardiac Center Medical Group (SDCC), Inc. physician or their designee. I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my records necessary to process my insurance claims. I have the right to rescind this authorization at any time by providing a written notification to SDCC.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**
I certify that I have received and read a copy of the San Diego Cardiac Center Medical Group, Inc. Notice of Privacy Practices.

**CONSENT TO USE OF MAIL, PHONE, TEXTS, EMAIL, PATIENT PORTAL:**
I certify that I understand the privacy risks of the mail, phone calls/texts and e-mail including online access through our patient portal. I hereby authorize San Diego Cardiac Center Medical Group, Inc. to use the above communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results.

**LAB / X-RAY / DIAGNOSTIC / HOSPITAL SERVICES:**
I understand that I may receive a separate bill if my medical care includes medical services provided by another organization.

**PATIENT NON-COMPLIANCE:**
Multiple late cancellations and/or missed appointments are a sign of non-compliance as well as failure to follow physician prescribed treatments and instructions. Non-compliance may result in dismissal from the practice.

## Patient Financial Responsibility Disclosures

***Patient responsibilities:***

- **Information** – Accurate information regarding *current* insurance must be provided to the front desk.
- **Co-pay and Deductibles** –You are responsible for paying your co-pay on the day service is rendered. As a courtesy, claims will be submitted to your health insurance plan.
- **Medicare (non-HMO)** – We accept Medicare assignment. You are responsible to pay the annual deductible and 20% co-payment. Claims will be submitted to your secondary insurance as a courtesy.
- **Non-Covered Services** – If we provide services to you that are not covered by your health plan, you will be responsible for payment in full. You may be required to sign a waiver.
- **Self Pay/No Insurance Coverage** – Payment in full is expected on the day service is rendered.
- **Payment Arrangements and Plans** – Payment may be made with cash, check, debit or credit card. Payment plans must be made with the Billing Department in advance or on the day of appointment.
- **Collections** – If it is necessary to assign your account to a collection agency, you will be responsible for all their fees and costs. In addition, you may be dismissed from the practice.

***Service Charge Fees*** – A service fee will be charged to your account for the following reasons:

- **$10.00** – Late fee if payment is received after 30 days from first statement date.
- **$15.00** – Statement fee for co-pay not paid on the date of service
- **$25.00** – Fee for missed/cancelled appointment without a minimum of 24 hours in advance.
- **$25.00** – Returned check fee. If a second returned check occurs, the patient will be responsible for three (3) times the amount of check or $100.00, whichever is more.
- **$200.00** – Fee for missed/cancelled Nuclear Imaging Test without a minimum of 24 hours advanced notice. (Pharmaceutical drugs are ordered in advance specifically for each patient and cannot be used for another patient.)

**Your signature below confirms that you understand and consent to each of the above statements and constitutes agreement to pay for any services and/or fees disclosed on these forms.**

Patient Signature: _____ **DOB**:___/___/____ **Date:**___/___/____

*****If patient unable to sign - Caregiver, Parent or Guarantor sign below:***

Signature: _____ Relationship to patient:_____ Date:___/___/____