

REGISTRATION

(PLEASE PRINT)

Cardiology & Arrhythmia Consultants, Inc.

Date: _____

Patient: _____ Social Security # _____

Home Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Sex: Male Female Age _____ Birth date _____ Single Married Widowed Separated Divorced

Race (For research purposes): American Indian/Alaskan Native Asian/Pacific Islander Hispanic

Caucasian (NON-HISPANIC) African American (NON-HISPANIC)

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____

Birth date _____ Spouse Social Security # _____

Business Name and Address _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient? _____

Do you have Medical Insurance? No Yes ► If yes,

Name of Primary Insurance _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurance _____

Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____

How did you learn of our practice? _____

ASSIGNMENT OF BENEFITS/MEDICARE/AUTHORIZATION FOR TREATMENTS:

I hereby authorize treatment; and I request that payment of authorized Medicare benefits or other Insurance benefit be made either to me or on my behalf to Cardiology & Arrhythmia Consultants for any services furnished me by physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

Beneficiary Signature

Date