

Cardiology and Arrhythmia Consultants, Inc.

PATIENT REGISTRATION UPDATE

Name: _____ **D.O.B.** _____

Address: _____ **SSN** _____

City _____ **State** _____ **Zip** _____

Telephone: (Home) _____ (Work) _____ Ext. _____

(Cell) _____ E-Mail _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

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

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

Hispanic _____ Other _____

Insurance: 1. Primary _____

Subscribers I.D. _____ D.O.B _____

2. Secondary _____

Subscribers I.D. _____ D.O.B _____

Note: Please give receptionist insurance card and picture I.D. to copy.

Employer: _____

Address: _____

Position: _____

Please sign below.

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 release to the Health Care Financing Administration and its agents or my insurance carrier any information needed to determine these benefits or 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 the Medicare carrier as the charge, and the patient is responsible only for the deductible, coinsurance, noncovered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

Patient

Date