MIDLAND HEALTH

Permian Cardiology

Patient Information

Date_____Dr._____
How did you hear about us _____Primary Care Dr _____
Have you previously been seen by a PCI Dr.? _____Who? _____When?_____

Patient Information
Last name_____ First Name_____ M.I._____
Address_____City/State/Zip_____
Home Ph# _____Cell# _____Wk#_____
Consent to call YES/ NO Email_____
DOB _____ Sex: Male Female / Single Married Widowed Divorced
SS#_____DL#_____State_____
Employer/School _____Address_____
Primary Language _____Race _____Ethnicity_____
Medical History Authority Yes No

Guarantor info: Name_____DOB_____SS#_____
Address_____Phone#_____Relation_____
Emergency contact: Name_____Phone#_____
Address_____Relation_____
Insurance____ Medicare_____ Cash____

Primary Ins_____ Phone#_____
Primary Policyholder's Name_____DOB_____
ID#_____Group#_____Relationship to insured_____
Employer_____ Employer address_____
Employer phone# _____

Secondary Ins_____ Phone#_____
Secondary Policyholder's Name _____DOB_____
ID# _____Group# _____Relationship to insured _____

Assignment of Benefits/Release of Medical information: I authorize Permian cardiology (PCI) to release any medical information that may be necessary to process my medical/surgical claims. I request that payment of my insurance benefits be made on my behalf to PCI for any service furnished to me. This assignment will remain in effect until revoked by me in writing.

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

Patient or Guarantor_____Date_____

Permian Cardiology

Acknowledgement of Receipt of Notice and Consent to Use and Disclose Health Information

This acknowledgment of notice and consent authorizes Permian Cardiology to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices Permian Cardiology has a notice of Privacy Practices, which describes how we use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice and prior to signing this acknowledgment and consent.

Amendments We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment I voluntarily consent to receive medical and health care services provided by Permian Cardiology, employees and such associates, assistants and other health care providers. I understand that such services may include diagnostic procedures, examinations and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that Permian Cardiology may use health information exchange systems to electronically transmit, receive and./or access my medical information which may include, but is not limited to treatments, prescriptions, labs, medical and prescription history, and other health care information.

Please mark and agree to accept artificial messages by:
Phone Calls Yes No **Text messages** Yes No **Emails** Yes No

Acknowledgment and consent

I have reviewed the Notice Privacy Practices for Permian Cardiology. Permian Cardiology is authorized to use and disclose health information about patient listed below for treatment, payment and healthcare operations purpose consistent with its Notice of Privacy Practice.

Print name_____
Signature _____ Date_____
(or patient's personal representative)

Name of Representative_____ Relationship_____

MIDLAND HEALTH

Permian Cardiology

Cancellation Policy/No Show Policy
For Doctor Appointments & Procedures

1. **Cancellation/No Show for Doctor Appointment**
    a. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five ($25) fee; this will not be covered by your insurance company. A patient who is a no-show more than three (3) times is dismissed from the practice.

2. **Scheduled appointments**
    a. We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Print name Patient_____ Date_____
Signature Patient_____

Office Use Only

Patient Account#_____

MIDLAND HEALTH

Permian Cardiology

Financial Policy

Thank you for choosing Permian Cardiology as your healthcare provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time you have questions or concerns requiring further information, whether it is medical or business, our staff is available to assist you.

The following information outlines our policies regarding payment of your doctor's bill.

The cost of medical care is determined by the nature and complexity of the illness. There is no 'FLAT RATE' for examinations and treatment. You are given an **estimated** amount at the time of visit before checkout. After reviewing the physicians/providers documentation for the visit additional services/procedures maybe added to the visit.

Out-Of-Network Insurance Patients will be expected to pay the Out-of-Network deductibles and co-insurance at the time services are rendered. Permian Cardiology will file with your insurance company as a courtesy.

In-Network Insurance Patients at each visit, your current insurance card(s) will require presentation when 'signing in' at the front desk. The patient will be responsible for any co-payments, deductibles, co-insurance or non-covered services at the time of the visit.

Non-Insured Patients will be expected to pay in full the total charge for the services rendered. We do offer a discount for our non-insured patients.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 30 days. To avoid collection procedures your account must be kept current. If the accounts sent to collection then the physician/patient relationship is terminated.

Please sign to acknowledge you agree and understand policy.

Patient Name Print _____

Patient or Legal Guardian Signature_____

Date_____