CAPE FEAR CARDIOLOGY ASSOCIATES, P.A.

3634 Cape Center Drive • Fayetteville, North Carolina 28304 • (910) 485-6470

PLEASE PRINT

PATIENT DATA

Name: _____

Age: _____ Date of Birth: _____ Sex: _____ Social Security No.: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone No: _____ / _____ - _____

Employer: _____ Business Phone: _____ / _____ - _____ Ext.: _____

Employer's Address: _____

SPOUSE DATA

Spouse Name: _____ SS#: _____ Age: _____ Date of Birth: _____

Employer: _____

Employer's Address: _____

REFERRAL SOURCE DATA

Referring Physician Name: _____

Address: _____

LOCAL EMERGENCY CONTACT NOT LIVING IN HOUSEHOLD

Name: _____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy Policies for the above named practice.

SIGNATURE _____ DATE _____

I authorize release of information during the course of examination and treatment to provider designated and payment of benefits to Cape Fear Cardiology Associates, P.A. I hereby assign payment directly to said provider for any medical services performed. I agree to be responsible for payment of services determined by my insurance carrier as not medically necessary or noncovered services. I consent to treatment meaning providing, coordinating, managing healthcare and related services, including consultations and referrals, payment and healthcare operations. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

SIGNATURE _____ DATE _____

The intent of this document is to inform you of Cape Fear Cardiology Associates, P.A. financial policy. We are committed to providing you with the best possible care and service; therefore, your complete understanding of our financial policy as it relates to your financial obligations is essential.

All deductibles, copayments, and coinsurance are due at the time of service. As a service to our patients, we will bill your insurance company. Your insurance plan is an agreement between you and the insurance carrier; you are ultimately responsible for all your medical expenses, and we will look for you to pay any balances not covered by insurance. Nevertheless, every effort will be made to help you deal with your insurance carrier. Should there be unusual financial situations which make payment difficult, please feel free to discuss this with our Account Representative.

We accept cash, personal checks, money orders, travelers checks, MasterCard, and Visa as payment for services rendered.

Any past due balances may be subject to additional collection fees and we reserve the right to turn any over to collections if the account is in default of the payment obligation or compliance with this policy.

If you are unable to keep an appointment, please notify us as soon as possible so that we may use that time for other patients. Please arrive 15 minutes early to allow time to complete necessary paperwork. Medical emergencies or other unforeseen problems could delay your visit. If this creates any inconveniences, efficient rescheduling is available.

It is the policy of Cape Fear Cardiology Associates, P.A. not to discuss a patient's account information or medical record with anyone other than the patient unless the patient gives prior written consent. Patient records are confidential. We require the patient's written approval to release information to another party.

Cape Fear Cardiology Associates, P.A. will not become a third party to claims related to motor vehicle accidents or liability. All expenses related to medical treatment received at this office are the responsibility of the patient and are due when the service is rendered.

It is the policy of Cape Fear Cardiology Associates P.A. that a patient will be financially responsible for all charges incurred.

It is the policy of Cape Fear Cardiology Associates, P.A., their physicians and staff to refuse to render further services in the event I do not honor this financial agreement. I understand that for any service I do not pay in full at the time the service is rendered, I assign benefits for that claim to Cape Fear Cardiology Associates, P.A.

Having read and fully understanding the above information, I authorize Cape Fear Cardiology Associates, P.A. to submit appropriate information to my insurance company for processing of my claim.

Patient's Signature _____ Date _____

MEDICARE / CHAMPUS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 2801-2812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Patient's Signature _____ Date _____