Children's Cardiology of the Bay Area, Inc.

ADULT REGISTRATION FORM

PATIENTS NAME:_____ Birth Date:_____

Home Phone: ( )_____ Cell Phone: ( )_____

Address:_____ City:_____ State:_____ Zip:_____

Employer: _____ Business Phone: ( )_____

Patient Social Security #:_____

Spouse's Name: _____

Spouse's Employer:_____ Spouse's Business Phone:_____

Spouse's Social Security ##:_____

Is your spouse the primary subscriber of your insurance: ☐ **Yes** ☐ **No**

Emergency Contact Name:_____ Phone:_____

PAYMENT POLICY:

Balances are due within 30 days. There will be a $35.00 charge for all returned checks.

CO-PAYMEN'T'S ARE DUE AT THE TIME OF SERVICE. Patients with HMO's and PPO's of which we contract, will be responsible for co-pay amounts and deductibles provided all pre-authorizations have been obtained. A $10.00 administrative feel will be added to all copayments not paid on the day of service. It is the responsibility of the patient to maintain and verify eligibility with all state funded or private insurance companies. **HMO and PPO patients will be held financially responsible for all charges incurred which are not authorized, not a covered benefit, or determined to be not medically necessary or experimental. It is the responsibility of the patient to appeal these charges with the insurance company.**

A $200.00 fee will be charged for missed appointments not cancelled within (24) twenty-four hours prior to the scheduled appointment.

UNDERSTANDING, ASSIGNMENT AND RELEASE:

I have read and understand the payment policy. I authorize direct payment of medical benefits to Children's Cardiology of the Bay Area and authorize the release of any information from any entity in order to process this claim. I understand this assignment will stay in effect as long as the patient remains in this practice.

A late fee of Ten dollars ($10.00) per month will be assessed on any outstanding balances exceeding 30 days. In addition to the late fee if the account is sent to a collection agency a processing fee will be assessed separately from the collection agency's fees.

I understand that I must submit a current and valid insurance card in order to have the insurance company billed directly. I understand that if I fail to submit a valid and current insurance card or if I fail to provide a valid secondary insurance card I will be billed at the non-contracted rate for services payable within 30 days. I understand that I will be held financially responsible for any and all unpaid balance exceeding 30 days. I understand that any insurance disputes will be settled between the insurance company and myself and any unpaid balance will be due and payable to Children's Cardiology of the Bay Area upon receipt. Self-pay accounts are due at time of service. Notice to consumers: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov

Signature:_____ Date:_____

Please Print Your Name:_____

Children's Cardiology of the Bay Area

PAYMENT POLICY: (REQUIRED FOR REGISTRATION)

Balances are due within 30 days. Children's Cardiology of the Bay Area will bill the insurance company first. If you owe a balance our billing department will send you a statement. There will be a thirty-five dollar ($35.00) charge for all returned checks. Co-payments are due at the time of service. A ten dollar ($10.00) administrative fee will be added to all copays not paid on the day of service. It is the responsibility of the patient to maintain and verify eligibility with all state funded or private insurance companies. When you receive our statement you can send us a check or call our billing office and request for your outstanding balance to be charged to your credit card. If you do not pay your outstanding balance within 30 days we will automatically charge your credit card for the balance due.

HMO and PPO patients will be held financially responsible for all charges incurred which are not authorized, not a covered benefit, or determined to be not medically necessary or experimental. It is the responsibility of the patient to appeal these charges with the insurance company.

A late fee of Ten dollars ($10.00) per month will be assessed on any outstanding balances exceeding 30 days. A $200.00 fee will be charged for missed appointments not cancelled within (24) twenty-four hours prior to the scheduled appointment. In addition to the late fee if the account is sent to a collection agency a processing fee will be assessed separately from the collection agency's fees.

I authorize Children's Cardiology of the Bay Area to process credit card payment for any outstanding balances exceeding 30 days. Self-pay accounts are due at time of service.

Please Circle the type of card VISA or MasterCard.
(We **DO NOT** accept **D**iscover or **A**merican **E**xpress)

Credit Card Account Number: _____

Expiration Date: _____ 3 Digit Security Code on back of card: _____

Name on Credit Card: _____

Zip code for billing address: _____ Signature: _____

Name:_____Date:_____

Children's Cardiology of the Bay Area, Inc.

(adult consent)

Consent for Purpose of Treatment. Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Children's Cardiology of the Bay Area, Inc. for the purpose of diagnosing or providing treatment to me or of obtaining payment for my health care bills. I understand that diagnosis or treatment may be carried out only after this consent is signed.

I understand I have the right to request limitations as to how my health information is used or disclosed. The doctor is not required to agree to limitations that I may request. However, if the doctor agrees to the limitations I request, the restriction is binding on Children's Cardiology of the Bay Area, Inc.

I have the right to cancel this consent in writing, at any time except to the extent that Children's Cardiology of the Bay Area, Inc. or the doctor has taken action relying on the consent.

My "protected health information" means health information, including my demographic information, collected from me and received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. I also understand that postcards addressed to me may be mailed as follow-up reminders. I also understand that I may choose to receive "Electronic Protected Health Information" (ePHI) via an alternate form of communication via email if I provide an email address.

I understand I have a right to review the doctor's Notice of Privacy Practices prior to signing this document. The doctor has the right to change the privacy practices without notice. I may obtain a revised notice by calling the office and requesting a copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient:_____

Print Your Name: _____

Date:_____