Suffolk CARDIAC Care
Raja Varma M.D., F.A.C.C.

PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:_____

Gender: _____ Social Security: _____ Date of Birth: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Phone #: (H):_____ (Mobile):_____ (Work):_____

Email: _____ Marital Status: Married _____ Single_____ Other_____

Employment: Full Time_____ Part Time_____ Retired_____ Not Employed_____ School_____

Employer: _____ Phone #:_____

Address: _____ City: _____ State: _____ Zip_____

SPOUSE INFORMATION

Last Name: _____ First Name: _____ MI:_____ Gender:_____

Phone #: (H):_____ (Mobile):_____ (Work) _____

Social Security: _____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____

Gender:_____ Relationship to Patient: _____ Primary Number: _____ Secondary Number: _____

PRIMARY CARE PHYSICIAN

Physician Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

Fax:_____

REFERRING PHYSICIAN (If not Primary Care Physician)

Physician Name:_____

Address:_____

City:_____+_ State:_____ Zip:_____

Phone Number:_____

Fax:_____

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PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT NAME

Last Name: _____ First Name: _____ Date of Birth: _____

PHARMACY INFORMATION

Name of Pharmacy:_____

Address: _____ City:_____ State:_____ Zip_____

Phone Number:_____ Fax:_____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name:_____

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

Subscriber ID #:_____ Group #:_____Patient's Relationship to Insured: Self/Spouse/Child/Other

Insured Name (if not self):_____ SS#:_____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name:_____

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

Subscriber ID #:_____ Group #:_____Patient's Relationship to Insured: Self/Spouse/Child/Other

Insured Name (if not self):_____ SS#:_____ Date of Birth: _____

*ALL COPAYS ARE DUE AT TIME OF VISIT. WE ARE A SPECIALIST OFFICE COPAYS MAY VARY.

*NEW PATIENTS MUST HAVE MOST RECENT EKG AND LAST BLOOD WORK PRIOR TO SEEING THE DOCTOR.

*ANY MISSED APPOINTMENTS ARE SUBJECT TO A $30.00 MISSED APPOINTMENT FEE

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BILLING POLICY

Referrals:
It is the patient's responsibility to obtain referrals for initial and follow up visits, which must be presented to the receptionist prior to your visit. If you do not have out of network benefits and you choose to be seen without a referral, you will be responsible for payment of all services. If you choose to use your out of network benefits, arrangements must be discussed with our Billing Coordinator prior to your visit.

Workman's Compensation/No Fault Insurance:
Arrangements with our billing department must be made prior to your visit. Please contact them prior.

Copayments:
All copayments /co-insurance payments are due at the time of your visit.

Medicare:
We are participating providers of Medicare. Patients are responsible for 20% Medicare co-insurance and/or deductible (if applicable) UNLESS paid by your secondary insurance carrier. If your secondary carrier does not cover your co-insurance in full, you will be billed for the balance.

Medicare HMO:
If you are planning to join or have joined a Medicare HMO plan, you must notify our office/billing department so that we can update your records.

Insurance Policy:
It is the responsibility of the patient/insured to know the terms of their insurance coverage. Deductible/co-insurance withheld from payments is the patient's responsibility. Payments denied due to lapse of coverage/ termination, misrepresentation of information or failure to notify us of changes to your insurance, are the patient's responsibility.

If you have any further questions or concerns regarding any of the above policies, please feel free to contact our Billing Department/Coordinator with any questions you may have.

I verify the accuracy of the above information. I authorize the disclosure of my medical information and that payment for authorized services is made to the treating physician at Suffolk Cardiac Care, PLLC on my behalf.

Signature of Patient: _____ **Today's Date:** _____

Print Name: _____

Suffolk CARDIAC Care
Raja Varma M.D., F.A.C.C.

NON-MEDICARE PATIENTS

I request that payment of authorized benefits be made either to me or on my behalf to Suffolk Cardiac Care, PLLC for services rendered to me by my physician. I authorize any holder of medical information about me to release to my insurance company and/or its agents any information needed to determine these benefits and pay for these services.

Signature of Patient: _____ **Today's Date:** _____

Print Name: _____

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MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or my behalf to Suffolk Cardiac Care, PLLC for services rendered to me by my physician. I authorize any holder of medical information about me to release to the Nation Government Services, Inc. and its agents any information needed to detem1ine these benefits and pay for these services.

Signature of Patient: _____ **Today's Date:** _____

Print Name: _____

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MEDIGAP POLICY HOLDERS

I authorize payment of authorized benefits from my Medigap insurer to be made on my behalf to Suffolk Cardiac Care, PLLC for any and all services rendered to me until I revoke authorization.

Signature of Patient: _____ **Today's Date:** _____

Print Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from 3rd party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____

I allow my records to be released to: _____

_____

Relationship to Patient: _____

Patients Signature: _____

Today's Date: _____