|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION Name: Preferred Name: Marital Status:

|  |  |  |  |
| --- | --- | --- | --- |
|  Birth Date: | Sex: M/F | Social Security # (for insurance claim purposes):  |  |

 Mailing Address:(including state, zip code)

|  |  |  |
| --- | --- | --- |
|  Email Address (allows for access to the online Patient Portal):  | Home phone: | Cell phone:  |
| Work phone: | Allow appointment reminder texts?(Circle one) Yes No |
| We strive our best to maintain great communication with our patients.What is your preferred method of contact? (Circle one)  Mobile Home Email Work Patient Portal | Occupation: |
| Preferred Language: |

Family/Referring provider information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|

|  |  |  |
| --- | --- | --- |
| Family/Referring Provider:  | Phone # (if known):  | Fax # (if known):  |

 |  |

IN CASE OF EMERGENCY

|  |  |  |  |
| --- | --- | --- | --- |
|  Friend or family member: | Relationship: | Home phone: | Cell phone: |
|  |  |  |  |

preferred FACILITIESPreferred Clinical Lab address and/or Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Pharmacy address and/or Fax#:­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance information and SCHEDULING POLICYPrimary Insurance:                                                        Subscriber ID:                                                                   Secondary Insurance:                                                    Subscriber ID:                                                                 Tertiary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prescription Drug Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Scheduling Policy:** When a patient cancels without giving enough notice, they prevent another patient from being seen. I understand that I will be charged a $50 fee for no shows and appointments that are not cancelled by at least 1 business day.Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS**

I hereby authorize Du Cardiology to obtain medical records from all physicians, hospitals, or other health care professionals that have provided me medical care regardless of timeframe for continuation of cardiac care. These records may include, but are not limited to, the following information:

* Patient registration and insurance card
* Most recent progress notes
* Referral information
* Consultation note
* Most recent EKG
* Most recent stress test(s)
* Cath/stent report
* Operation report for open heart surgery
* Most recent lab results
* Problem lists
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This includes disclosure of medical information via secure fax.

This authorization may be revoked at any time by sending the request in writing to:

Pingfeng Du MD, INC

345 Saxony Rd suite 202

Encinitas, CA 92024

Phone: 760-230-6660 Fax: 760-230-6626

 **This authorization will expire: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(5 years is the maximum in certain states if you plan on or happen to receive care there)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**

 **Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if you are the patient, write “self”)**

*Please fax medical records to:*

*Du Cardiology at (760) 230-6626*

**AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS/OTHERS**

In accordance with the HIPAA Privacy Rule’s requirements, please fill the below to release test results to family members or other individuals. Many of our patients allow family members such as their spouse, parents, children, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient’s consent. Signing this section will grant us consent to release appointment information, test/procedural results, and billing information to the individuals listed below. In the event in which you are in severe medical condition, the law stipulates that we have the right to waive these rules.

I authorize Du Cardiology to release my medical and/or billing information to the following individual(s):

1. Emergency Contact (by default) \_\_\_\_\_\_Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or

☐ I do not authorize any other individual to receive my medical and/or billing information from this office.

**Patient Information:**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

I have the right to revoke this consent in writing.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**

**AUTHORIZATION AND AGREEMENT TO PAY BENEFITS TO DU CARDIOLOGY**

I certify that the listed insurance information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Du Cardiology. My insurance contract is an agreement between me and the insurance company, and as the subscriber, I am responsible for the terms of that agreement. I understand that my insurance determines the processing of my claims and sends an explanation of benefits (EOB) to me and Du Cardiology.

After proper processing of medical claims, I understand that I am financially responsible for any balance not covered by insurance and will be forwarded to the collection agency if the balance is not paid after **90 days** of the billing statement. If a payment plan is needed, I will inform the office within **14 days** of the billing statement. Once a payment plan is established, it is my responsibility to inform the office if I have any changes or delays in the payment plan within 2 weeks. Failure to do so will result in my balance being forwarded to collections.

I understand that the billing statements are defaulted to being sent to the listed mailing address unless I opt to receive them electronically through Du Cardiology Patient Portal.

**INSURANCE ELIGIBILITY AND BENEFITS**

I understand that it is my responsibility to find out if Du Cardiology is in network with my insurance plan. When procedures and visits are scheduled at Du Cardiology or at another facility, I understand that the office will only check with my primary insurance if any precertification or prior authorization is needed. Du Cardiology is not liable for finding out any exact cost of my procedures or visits that the insurance may render. Additionally, it is my responsibility to ask the office for the billing information and contact my insurance to find out for the following:

* Deductible, coinsurance, out-of-pocket, eligibility, copay, etc.
* In-network benefits or out-of-network benefits
* Whether or not procedure or visit is a payable benefit
* Questions about claims and EOBs

Under circumstances where a payment is expected from the insurance, Du Cardiology will make two attempts to resolve a denied claim. If the claim is not resolved by then, Du Cardiology has to right to drop the charge of the performed service at the cash rate.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**