PATIENT REGISTRATION FORM

SAN DIEGO CARDIAC CENTER Medical Group, Inc.
www.sdcardiac.com

Kearny Mesa Office
3131 Berger Avenue
Suite 200
San Diego, CA 92123
858-244-6800

Chula Vista Office
890 Eastlake Parkway
Suite 205
Chula Vista, CA 91914
858-244-6867

Office Use Only

Today's Date _____

Acct # _____

PATIENT INFORMATION

Please Print

Last Name: _____ First Name: _____ Middle: _____DOB: _____

Address: _____ Mailing: _____City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Email Address: _____ Social Security #: _____

Sex: ☐ Male ☐ Female ☐ Other _____ Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

RACE/ETHNICITY/LANGUAGE

Do you consider yourself to be Hispanic or Latino? ☐ No ☐ Yes

Which category best describes your race?

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ White

☐ Black or African American ☐ Other ☐ Decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other _____(Please notify our office in advance of your appointment if you will require translation services).

INSURANCE INFORMATION

PRIMARY CARRIER: _____ Subscriber Name: _____DOB: _____

SECONDARY CARRIER: _____ Subscriber Name: _____DOB: _____

Work-related injury/illness? ☐ No ☐ Yes Work Comp Date of Injury _____ Claim #_____

Financial Guarantor (if different) Last _____First _____DOB: _____

ELECTRONIC COMMUNICATIONS

Our office communicates through different electronic means including our secure patient portal, phone, and text messaging for appointment reminders.

I authorize San Diego Cardiac Center to contact me by the following methods:

• Cell Phone • Text Message • Home Phone • Secure Email • Online Patient Portal

☐ It is okay to leave detailed messages on my voicemail

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

SAN DIEGO CARDIAC CENTER
Medical Group, Inc.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS PATIENT FINANCIAL RESPONSIBILITY FORM

Last _____ First _____ DOB: _____

Thank you for choosing San Diego Cardiac Center (SDCC). We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign the following documents to acknowledge your understanding and authorization for treatment, payment and patient financial policies.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to the practice, San Diego Cardiac Center Medical Group, Inc., to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to San Diego Cardiac Center Medical Group Inc.

I assign all insurance benefits for treatment to be paid directly to San Diego Cardiac Center Medical Group Inc. and request that this assignment remain on file with my insurance carrier.

_____ Signature _____ Date

PATIENT FINANCIAL RESPONSIBILITIES

- I understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance at each visit, and I will be responsible for any charges incurred if the information provided is not correct, updated or is not payable according to my insurance coverage.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that if I am a self-pay patient payment is due in full at the time of service.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include but are not limited to:
    - $10.00 late fee if payment is received after 30 days from first statement date.
    - $15.00 statement fee for copay not collected on the date of service.
    - $25.00 returned check fee. If a second returned check occurs, I am responsible for three (3) times the amount of the check or $100.00, whichever is more.
    - $25.00 fee for late cancellation (less than 24-hour notice) or missed appointment.
    - $25.00 form completion fee (i.e., EDD, FMLA, DMV, life insurance forms).
    - Medical Records Copy Fees are available upon request. Fees are due prior to release of records.
    - $200.00 fee for late cancellation (less than 24-hour notice) or missed appointment for any Nuclear Imaging Test.
    - If it is necessary to assign your account to a collection agency, you will be responsible for all their fees and costs. In addition, you may be dismissed from the practice.

_____Initials

PATIENT NON-COMPLIANCE

Multiple late cancellations and/or missed appointments, as well as a failure to follow physician prescribed treatments and instructions, are a sign of non-compliance and may result in dismissal from the practice.

_____Initials

SAN DIEGO CARDIAC CENTER
Medical Group, Inc.

HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND RELEASE OF INFORMATION

Last _____ First _____ DOB: _____

I authorize San Diego Cardiac Center Medical Group, Inc. and its staff to use and disclose the protected health information described below, to the individuals named with the disclosures specified for each. Additionally, I understand my health information serves as a basis for planning my care and treatment and is a means of communication among the many healthcare professionals, including insurances who contribute to my care. I authorize release of my medical records to providers involved in my care in order to ensure continuity of care.

Signature below is acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review the "Notice of Privacy Practices" available at the Front Desk or at www.sdcardiac.com.

_____ Signature

Please complete the sections below if you would like an authorized representative to have access to call or receive medical information on your behalf.

Authorized Representative 1:

Name: _____ Relationship: _____ DOB: _____ Ph: _____

- ☐ **All** medical history and treatment records including sensitive issues such as sexually transmitted diseases and mental health records.
- ☐ All medical history **excluding** sensitive issues such as sexually transmitted diseases and mental health records.
- ☐ Billing Information (i.e., billing profile, balance, charges)

Authorized Representative 2:

Name: _____ Relationship: _____ DOB: _____ Ph: _____

- ☐ **All** medical history and treatment records including sensitive issues such as sexually transmitted diseases and mental health records.
- ☐ All medical history **excluding** sensitive issues such as sexually transmitted diseases and mental health records.
- ☐ Billing Information (i.e., billing profile, balance, charges)

Primary Care Doctor: _____ Phone:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and that the revocation will not apply to information already released prior to revocation date.

_____ _____

Signature of Patient/Legal Representative Date

COMPLETE ACKNOWLEDGEMENT

I have read and understand the acknowledgments, disclosures, privacy, billing and office policies of San Diego Cardiac Center Medical Group, Inc. included within this packet. I further acknowledge that this information is subject to change with or without prior notice.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE