PATIENT INFORMATION REGISTRATION FORM

(Please print clearly)

Patient's Full Name: _____Age: _____ Sex: □ M □ F

Date of Birth: _____ Social Security No.:_____

Address: _____City: _____ State: _____Zip: _____

Are you: □ Married □ Single □ Divorced □ Separated □ Widowed

Home Phone: _____Cell Phone: _____

Patient's Employer: _____ Phone No.:_____

Address: _____ Occupation: _____

City: _____State:_____ Zip: _____Spouse: _____

Spouse's Employer: _____ Phone No.:_____

Occupation: _____ _____ Spouse Date of Birth: _____

Please check one: **Race:** □ Black □ White □ Hispanic □ other _____□ Prefer not to answer

Please check one: **Preferred Language**: □ English □ Spanish □ other _____□ Prefer not to answer

Please check one: **Ethnicity:** □ White American □ Hispanic/Latino □ African American □ Asian American

□ American Indian □ mixed □ other _____□ Prefer not to answer

In case of emergency contact (other than spouse):_____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Phone No: _____

REFERRAL INFORMATION: (Please tell us how you were referred to our practice)

Physician/Other: _____

PRIMARY INSURANCE CARRIER NAME:_____

TREATMENT AUTHORIZATION:

I hereby authorize Delta Clinics, PLC and its associates to undertake medical treatment, diagnostic testing as deemed medically necessary.

PATIENT CONFIDENTIALITY:

I, _____ authorize you to speak with my **(circle)** spouse son daughter other _____ about anything related to my health including but not limited to my medical condition and medications I'm currently taking and any and all other information that will be helpful pertaining to me, or to help me remain stable while in your care. For authorization to speak to my family member when calling, I will provide them with a password. The password is _____.

PAYMENT AUTHORIZATION:

I, _____ hereby authorize _____, M.D. to furnish information concerning services rendered. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be as valid as the original. In the event my account should become delinquent, I will be responsible for all collection fees. These fees will include a 15% service charge and any legal fees incurred through the collection process. **NOTE:** All payments due because of patient's failure to cancel appointment will be billed direct to the patient for payment. Reimbursement from Insurance will be patient's responsibility. Obtaining referral information is the patient's responsibility.

**** ALL CO-PAYS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED ****

_____ _____

SIGNATURE (PATIENT OR PARENT IF UNDER 18 YEARS OF AGE) **DATE**

SELF PAY PATIENTS: Delta Clinics, PLC is happy to serve patients that do not have insurance and/or patients that are self-pay. It should be noted that deposits are required for the services listed below on the day that the service is rendered.

Procedure	**Deposit Required**	**Procedure**	**Deposit Required**
Office Visit – Established Patient	$ 50.00	Holter Monitor	$ 75.00
Office Visit – New Patient	$ 100.00	Heart Catheter	$ 250.00
Echocardiogram	$ 200.00	Peripheral	$ 600.00
Echo with Contrast	$ 250.00	PPM/AICD Insertion	$ 250.00
Vascular Ultrasound	$ 200.00	ABI	$ 100.00
CT/CTA Scan	$ 400.00	PFT	$ 75.00
Stress Test – with Nuclear Medicine	$ 400.00	Thyroid Biopsy	$ 200.00
Stress Test – Treadmill Only	$ 100.00	Venous Ablations	$ 600.00
Renal Ultrasound	$ 50.00	EECP	Speak to billing

I understand that as a self-pay patient, I am responsible for the above listed deposit amounts for services provided by Delta Clinics, PLC on the day the services are delivered. I will be billed for the remaining amount of the cost of the service.

_____

Signature (Patient or parent if under 18 years of age)

Advance Directives

Are you interested in learning about advance directives regarding your health care? (This is a written document in which you specify what type of medical care you want if in the future, you lose the ability to make that decision).

Yes, I am interested _____ No, I am not interested at this time _____

Patient Signature: _____ Date: _____