VIRGINIA HEART

Excellence in Cardiovascular Care

Patient Registration

Please present insurance cards and photo ID at the front desk.

Today's Date: _____

Patient Account Number: _____

(Please Complete Both Pages and PRINT all Information)

PATIENT INFORMATION

PATIENT FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH MM / DD / YYYY	AGE

PRESENT ADDRESS Number & Street,	City,	State	ZIP Code

SEX M F	MARITAL STATUS Single Married Divorced Widowed	SOCIAL SECURITY #

I understand that as part of my health care, Virginia Heart will need to contact me from time to time for the purposes of reminding me of an appointment (via phone,text and/or email), or communicating clinically relevant information that may be pertinent to my medical treatment plan.

By providing my contact information below, I hereby authorize Virginia Heart to contact me in the following ways:

HOME PHONE [Phone Reminders]	WORK PHONE	MOBILE PHONE [Text-Msg Reminders]	EMAIL ADDRESS [Email Reminders]

Please select your Preferred Communication Method for Preventive Care Reminders: Mail Phone Patient Portal

EMPLOYER NAME:	OCCUPATION:

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:

ETHNIC GROUP: Hispanic or Latino / Not Hispanic or Latino

PREFERRED LANGUAGE:

RACE: American Indian or AK Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

PRIMARY INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY:	IDENTIFICATION #	GROUP #

ADDRESS: Number & Street,	City,	State	ZIP Code

POLICY HOLDER - FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH MM / DD / YYYY	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE INFORMATION

SECONDARY MEDICAL INSURANCE COMPANY:	IDENTIFICATION #	GROUP #

ADDRESS: Number & Street,	City,	State	ZIP Code

POLICY HOLDER - FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH MM / DD / YYYY	RELATIONSHIP TO PATIENT

SPOUSE INFORMATION

SPOUSE FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH MM / DD / YYYY	AGE

HOME PHONE	DAYTIME PHONE	MOBILE PHONE	SOCIAL SECURITY #

EMPLOYER NAME:	OCCUPATION:

PLEASE COMPLETE 2nd PAGE

Patient Last Name: _____

Patient Account Number: _____

PATIENT AUTHORIZATION

Note: Patient Authorization CANNOT be altered.

I, _____, hereby authorize Virginia Heart/Inova HealthCare Services to apply for benefits on my behalf for covered services rendered by Virginia Heart/Inova Health Care Services. I authorize and assign payment of such benefits be made directly to Virginia Heart/Inova Health Care Services, or in case of Medicare Part B benefits, to myself or to the party who accepts assignment. I authorize Virginia Heart/Inova Health Care Services to release any necessary information, including but not limited to my medical information, for purposes of furthering my medical care and for processing and receiving payment for services rendered to me, toother providers in my care, to my insurance carrier or its designees, or in the case of Medicare Part B benefits, to the Social SecurityAdministration and/or the Centers for Medicare/MedicaidServices or their respective designees. I am aware that any charges not covered by my insurance are my personal financial responsibility.A copy of the authorization may be used in place of the original.

I agree to promptly pay for the services rendered for me, or the above named patient. If I fail to meet my financial commitment to Virginia Heart/Inova Health Care Services and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

I further agree to pay for any missed appointments of which I did not notify the medical office within 24 hours of the appointment.

To all HMO & PPO patients: You are responsible for following the guidelines of your insurance carrier and for obtaining all necessary authorizations and referral numbers in order for us to properly file your claim.

This authorization may be revoked by me or Virginia Heart/Inova Health Care Services at any time in writing.

SIGNATURE OF PATIENT / LEGAL GUARDIAN: _____ DATE: _____

** If signing as POWER OF ATTORNEY, Power of Attorney document MUST be presented to the office.**

HIPAA CONFIDENTIALITY CLAUSE

This is NOT a Release of Information Authorization Form

I authorize the verbal release of personal health information relevant to my cardiac care, such as test results, appointment information, etc. to the following individuals: I understand that this consent will remain in effect until revoked in writing.

AUTHORIZED INDIVIDUAL	RELATIONSHIP	AUTHORIZED INDIVIDUAL	RELATIONSHIP

( ) I only authorize the release of information relevant to my cardiac care to myself.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been made aware of the Virginia Heart Notice of Privacy Practices, that a copy is available in the patient waiting room, or available on the practice website at www.VirginiaHeart.com.
Additionally, a copy is available to me upon request in the office.

SIGNATURE OF PATIENT: _____ DATE: _____

PATIENT PRINTED NAME: _____

OFFICE USE ONLY:
I attempted to obtain the patient's signature in Acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: *Initials:* *Reason:*