



# Patient Registration

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

## VIRGINIA HEART

Excellence in Cardiovascular Care

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>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, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Virginia Heart to contact me in the following ways:</i>					
HOME PHONE **	WORK PHONE	MOBILE PHONE	EMAIL ADDRESS		
<b>**NOTE: The "Home Phone" number is used for Appointment Reminder calls**</b>					
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:		

# Patient Registration (Page 2)

Patient Last Name: \_\_\_\_\_

Patient Account Number: \_\_\_\_\_

## PATIENT AUTHORIZATION

\*Note: Patient Authorization CANNOT be altered\*.

I, \_\_\_\_\_, hereby authorize Virginia Heart (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices), to apply for benefits on my behalf for covered services rendered by Virginia Heart (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices). I authorize and assign payment of such benefits be made directly to Virginia Heart (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices), (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment). I authorize Virginia Heart (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices) 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, to other providers in my care, to my insurance carrier or its designees, or in the case of Medicare Part B benefits, to the Social Security Administration and/or the Centers for Medicare/Medicaid Services 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 (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices) 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 (Arlington Office) or Virginia Heart/Inova Health Care Services (all other offices) 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](http://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: