

PATIENT REGISTRATION INFORMATION
PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME _____ FIRST NAME _____ INITIAL _____

DATE OF BIRTH _____ SEX M F SOCIAL SECURITY _____

MARITAL STATUS S M W D Other _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

SPOUSE NAME _____ INSURANCE COMPANY _____

RACE White Black Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native Hispanic Other

ETHNICITY Hispanic/Latino Non-Hispanic/Latino Unreported/Refused

LANGUAGE English Spanish French Arabic Chinese Sign Language

EMPLOYER _____ WORK PHONE _____

Responsible Party Information (for patients under 18 and other dependent patients)

Name: _____ Relationship to patient: _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: F M Phone: _____ Home Cell Other
MM/DD/YYYY

Emergency Contact

Name: _____ Phone: _____ Relationship to patient: _____

<p>Patient's Insurance Information</p> <p>Primary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>	<p>Secondary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>
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Patient Registration Form (Continued)

Assignment of Benefits

I authorize Patient Central via Lansing Cardiovascular Consultants, P.C. to release such information from my patient records as is required in order to receive reimbursement for any billings rendered relating to my treatment. I request that payment be made either to me or to Lansing Cardiovascular Consultants, P.C. for medical services provided to me. In making this authorization I understand and agree to pay any unpaid balance to include deductible and coinsurance if applicable.



Signature of Patient or Legal Guardian

Date

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.



Signature of Patient or Legal Guardian

Date

****For Medicare Patients Only****

I request that payment of authorized Medicare benefits be made on my behalf to Lansing Cardiovascular Consultants, P.C. and/or Patient Central for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

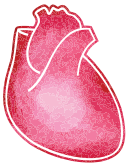
Patient's MEDICARE Number (HIC) _____

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.



Signature of Patient or Legal Guardian

Date



Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

Yes No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

Yes No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?

Email Cell Text Other

Yes No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

Yes No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

Yes No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

Please list any physicians you would like copies of office notes and test results sent to.



Signature of Patient or Legal Guardian

Date