East Atlanta Cardiology
Patient Registration

Name:____ Date:______________________

Mailing Address:____
(Street) (City) (State) (Zip)

Home Phone:__________________________Work Phone:__________________________

Cell Phone:____________________________SSN:_______________________________

Sex:_____________ Date of Birth:_________________________

Occupation:____________________________ Employer:__________________________

____

Emergency Contact:_____________________________ Phone Number:______________

Relationship:_________________________________

**Does East Atlanta Cardiology have permission to discuss your care with the above listed contact? YES or NO

Primary Insurance________________________________Policy#___________________

Insured's Name____________________________Insured's DOB:___________________

Insured's SSN:_____________________________ Group#________________________

Secondary Insurance________________________________Policy#_________________

Insured's Name____________________________Insured's DOB___________________

Insured's SSN:_____________________________ Group#________________________

Pharmacy Name:_______________________________Phone Number:_______________

Address:____

Referring Physician:_____________________________Phone Number:______________

I have completed this form accurately, truthfully and completely. Office Policy: I understand and agree that I will be responsible for any balances not covered by my insurance company. I agree that I will be assessed a $25 fee for any appointments that are not cancelled within 24 hours prior to my scheduled appointment. In the event that my account balance is 30 days past due, I agree that I will be assessed a monthly $10 fee/rebilling fee. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (15%), attorney fees, court costs etc. Any NSF/returned checks will be assessed a $40 fee.

Authorization and release of information: I hereby authorize East Atlanta Cardiology and its affiliates to release information contained in my medical records for the purpose of treatment, payment and operations as follows: 1) To my insurance company(s), their agents, or third party payor, and/or government or social service agencies which may or will pay for any part of my medical care; 2) As mandated by law; 3) To alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or my family for care.

I have received and agree to Office/Financial Policies.

Patient Signature:____Date:_____________________