CARDIOLOGY of VIRGINIA
Where Your Heart Matters Most

13572 Waterford Place
Midlothian, VA 23112
Ph: 804.560.8782
cardiovirginia.com

Patient History & Information

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Email: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Race: ☐ African American ☐ Alaska Native ☐ American Indian ☐ Asian

☐ Hispanic ☐ White ☐ Other: _____ ☐ I decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Contact: ☐ Cellphone ☐ Home Phone ☐ Email ☐ Other: _____

Have you had or ever been treated for the following conditions? (check all that apply):

☐ Headaches	☐ Emphysema	☐ Heart Attack
☐ Arthritis	☐ Skin Disorders	☐ Rheumatic Fever
☐ Seizures	☐ Lung Disorders	☐ Heart Disease
☐ Bleeding Disorders	☐ Anxiety/Depression	☐ Stroke
☐ Ear, Nose, and Throat	☐ Tuberculosis	☐ Congestive Heart Failure
☐ Kidney-Bladder Infection	☐ HIV-AIDS	☐ Varicose Veins
☐ Asthma	☐ Circulatory Problems	☐ High Blood Pressure
☐ Diabetes	☐ Cancer	☐ GI (stomach, bowel, liver)
☐ Bronchitis	☐ Dizzy/Fainting Spells	☐ High Cholesterol
☐ Thyroid	☐ Glaucoma	☐ Other: _____

Are you currently under the care of a Skilled Nursing Facility? ☐ Yes ☐ No

Name and address of facility: _____

_____

Thank you for your responses. Please return this form to the front desk now.

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Consent for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

We use information that you provide us, including health information, to carry out treatment, payment, and healthcare options. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionist or by calling our privacy officer at 560-8782.

You have the right to request that we restrict the use of your health information to carry out treatment, payment, or healthcare operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions taken in reliance on the consent prior to the time you revoke it.

I understand and have been provided a copy of a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment, and healthcare operation purposes.

I give Cardiology of Virginia permission to discuss my medical information with the following people:

Name: _____ Phone: _____

Relationship: _____ Emergency Contact? ☐ Yes ☐ No

Name: _____ Phone: _____

Relationship: _____ Emergency Contact? ☐ Yes ☐ No

Name: _____ Phone: _____

Relationship: _____ Emergency Contact? ☐ Yes ☐ No

Name: _____ Phone: _____

Relationship: _____ Emergency Contact? ☐ Yes ☐ No

Signature (patient or representative): _____ Date _____

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Authorization for the Release of Information

Patient Name: _____ Date of Birth: _____

I authorize the release of my medical records to Cardiology of Virginia.

Social Security #: _____ Signature: _____

To Our Patient: This authorization will be placed in your record and accessed in the event that our physicians need medical records from another physician, hospital, or medical facility.

Records requested from:

(This information will be completed when required.)

Please fax records to:

804.525.2525

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Conditions of Registration and Financial Policy

Patient Name: _____ Date of Birth: _____

Basic Financial Policy: Payment is due and payable at the time of service unless other arrangements have been made.

Co-payments and Deductibles: All co-payments and deductibles required by your insurance company contract are due at the time of service. You may be asked to reschedule the appointment if you are not prepared to make this payment. If you do not have your payment on the date of service and are unable to reschedule your appointment, you will have 7 calendar days to deliver payment to our office. If we do not receive payment in our office within the 7 day period, your account will be charged an additional $15.

For Patients with Commercial Insurance: You are responsible to know your insurance benefits, including what is not covered. We will bill insurance companies which whom we have a current contract. To do this, we require that you provide us with current and complete information. Given that the agreement with your insurance carrier is private; we do not routinely research why a given insurance company has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, please note that our fees are due and payable in full from you. Payment arrangements available, subject to practice approval.

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

Returned Checks: In addition to the face value of the check, or each check returned to us by your bank, you will be assessed a "bank returned check fee" equal to the amount charged to us by our bank, plus a $35 processing fee.

Unpaid Balances: Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within thirty (30) days of the billing date. All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum. If your unpaid balance is turned over to an attorney or collection agency for collection, you also agree to pay all costs associated with collection, to include attorney fees, equal to 33% of the unpaid balance.

Late Appointment Policy: If you are 15 minutes late for your appointment, you may be asked to reschedule.

Forms: There will be a charge of $20 for completion of medical forms. Payment is due when you make the request. Please allow 14 business days for the completion of forms.

Medical Records: We will provide you a copy of your medical records within 14 days upon written request at no charge.

Medication Refills: Please contact your pharmacy for prescription refills and allow 48 hours for processing. I have read, understood, and agree to be bound by the terms of this financial policy.

Signature: _____ Date _____

MEDICARE PATIENTS: SIGNATURE ON FILE

I request and authorize payments of Medicare benefits be made to Cardiology of Virginia, Inc. for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to adjudicate these benefits for services. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, Cardiology of Virginia agrees to accept the charge determination of the Medicare carrier as the full charge, and I understand that I am responsible for the deductible, coinsurance, and any non-covered services.

Patient Initials _____

ALL PATIENTS: ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Cardiology of Virginia, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I remain financially responsible for all charges whether or not the charges are paid by said insurance to the extent permitted by law. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Patient Initials _____