Carient
Heart & Vascular

Patient Registration

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Mailing Address: _____

City _____ **State:** _____ **Zip:** _____

Email Address: _____ **Social Security #:** _____

Preferred Language: _____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ M ☐ S ☐ D ☐ W **Gender:** ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Other

Employment Status (Circle One): Employed Self-employed Unemployed Retired

Home Phone (Primary Y/N): _____ **Cell Phone (Primary Y/N):** _____

Office Phone: _____ **Primary Care Physician (if different):** _____

Phone # _____ **Emergency Contact Name:** _____

Relationship: _____ **Phone #:** _____

How did you hear about us?: _____

Primary Insurance Company

Policy Holder: _____ **Relationship to Patient:** _____

Policy Holder's Employment Status (Circle One): Employed Self-employed Unemployed Retired

SSN# of Policy Holder: _____ **Date of Birth:** _____

Primary Insurance Company: _____

Secondary / Supplemental Insurance Company

Policy Holder: _____ **Relationship to Patient:** _____

Policy Holder's Employment Status (Circle One): Employed Self-employed Unemployed Retired

SSN# of Policy Holder: _____ **Date of Birth:** _____

Secondary Insurance Company: _____

Patient Consent - Release of Medical Information

I, _____ give my permission to any of the doctors or staff of Carient to speak to the following people regarding my medical care:

1. _____
2. _____

Carient
Heart & Vascular

Notice of Cancellation Policies

Carient Heart and Vascular will implement the policies outlined below.

OFFICE VISIT: 24 hours notice is required to cancel an office visit appointment. The following fees will be charged for no show appointments and cancellations with less than 24 hours notice:	New Patient Visit Established Patient Visit Nursing Visit	**$150** **$75** **$25**
DIAGNOSTIC TESTS: 48 hours notice is required to cancel a procedure appointment. The following tests will be charged $150 for all no show appointments and cancellations with less than 48 hours notice.	Stress Test Stress Echo Carotid Doppler Sleep Tests	Echocardiogram Thallium Stress Lower Extremity
DIAGNOSTIC DEVICES: There will be a $50 charge per day for Holter Monitors that are not returned on time. The following fees will be charged for lost or damaged monitors:	Holter Monitor Pouch Set Compact Flash Card Lead Wire Set	**$795** **$35** **$40** **$35**

Copays are a part of your contract with your insurance company and by law are due at the time of service. If you are unable to pay your copay on the date of service, by signing this document you are agreeing to pay a $25.00 re-bill fee along with your original copay that is due today.

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS

I hereby authorize direct payment of medical/surgical benefits to Carient for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Carient to release any medical or incidental information that may be necessary for either medical care or financial benefits. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any collection fees associated with balances on my account. I agree that I am fully responsible for payment for all services rendered to me. If my account is referred to collections, I understand and agree that I will be responsible to pay, in additional to the original amount owed, any and all costs of collections including, but not limited to, attorneys' fees, court costs, and a collection referral charge in the amount of twenty five percent (25%) of the original amount owed. I understand that if I fail to comply with these polices, I may be subject to the charges outlined above. I also understand that missed appointment charges must be paid before subsequent appointments can be honored.

In addition, by my signature below, I consent to receive email, text messages and calls from Carient Heart and Vascular and its business associates for my protected health care and other services, including payment and billing, at the email address and phone number, including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.
I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that email communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting Carient Heart and Vascular or utilizing the opt-out method that will be identified in the application communication.

By signing this consent, I understand and authorize communications from Carient Heart and Vascular to my email and phone number/s provided above. Per my below signature, I also certify that I have read and understood Carient Heart and Vascular's Notice of Privacy Practices.

Patient or Responsible Party: _____Date: _____