PATIENT INFORMATION			
NAME (Last, First, Middle)	Preferred Name	Date of Birth	Gender

LOCAL ADDRESS	**PHARMACY NAME**
CITY, STATE, ZIP	ADDRESS
PRIMARY PH # CELL #	CITY, STATE, ZIP
EMAIL	**PHONE #** **FAX #**
Emergency Contact Name	
Emergency Contact #	
Emergency Contact relationship	
PRIMARY CARE PROVIDER NAME	PHONE #

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	

SECONDARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	

X _____ _____/_____/_____

SIGNATURE OF PATIENT/GUARDIAN DATE .

RELEASE OF INFORMATION

Name of Patient: _____ **Date of Birth:** _____/_____/_____

I authorize:

Cardiology of Atlanta, P.C.

Dr. Hector Malave or Dr. Matthew Wilson

755 Mount Vernon Hwy NE Suite 530 Atlanta, GA 30328

Ph: 404.252.7970

Fx: 404.250.0553

To use, disclose and discuss my private health care information for the purpose of ongoing healthcare management with **the following doctors/ facilities:**

Primary Dr / Facility / Other Specialists:_____
(Name of person, class of persons, or organization with whom your protected health information may be exchanged)

Address:_____ Ph:_____ Fx:_____

HEALTH CARE INFORMATION WHICH CAN BE SHARED BETWEEN OFFICES:

❑Complete Medical Record

❑Hospital Medical Records

❑History & Physical/Consultations/Progress Notes

❑Radiology/Imaging Reports and/or Radiology Films

❑Laboratory/Pathology Reports

❑Sexually transmitted disease

❑HIV/AIDS –related information

❑Alcohol/Drug Records and/or HIV Test Results

❑Alcohol/substance abuse

❑Billing Records

❑A Representative of COA may discuss my PHI

❑Mental health services

This authorization will expire on the following date: ❑___/___/___ or ❑ Does not expire

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits from COA. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand COA may charge a processing fee for copying services. If I have questions about disclosure of my health information, I can contact the Medical Record Department at Cardiology of Atlanta. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. Additional information regarding the individual's right to revoke an authorization is found in COA's Notice of Privacy Practices.

X_____ Date: _____/_____/_____

Signature of Patient

Or Patient representative & relationship_____

Disclosure of Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home _____ Cell _____ Work_____

❑OK to leave detailed message on voicemail at home

❑OK to leave detailed information on cell phone voicemail

❑OK to leave detailed information on work voicemail

❑OK to fax information to the following fax # _____

❑OK to mail information to my home address on file

❑OK to leave detail information with the following people:

_____ _____

❑ONLY leave a call back # and I will return your phone call

I understand that I have the right to revoke this authorization at any time, expect to the extent that the person(s) to whom I have authorized such use/or disclosure have acted in reliance upon this authorization. In order to revoke this authorization, I must provide CARDIOLOGY of Atlanta, P.C. in writing, specifically revoking this authorization.

_____ _____/_____/_____

Patient Signature Date

Printed Name _____

Acknowledgement Receipt of Privacy Notice

I have been provided with a copy of the "Notice of Privacy Practices" from Cardiology of Atlanta, PC

_____ _____/_____/_____

Signature of Patient or Patient's Representative Date:

_____

Printed Name of Patient or Patient's Representative

_____

If Applicable, Relationship to Patient

CARDIOLOGY of ATLANTA

755 Mt. Vernon Hwy, NE
Suite 530
Atlanta, GA 30328
Ph : 404-252-7970
Fax : 404-250-0553

Consent for Medical Treatment

I, _____, consent to medical treatment as deemed medically necessary and appropriate by my Cardiology of Atlanta physician.

- Medical treatment may include, but is not limited to, performing an EKG, ordering laboratory testing, administration of medications, and other diagnostic services to assess my cardiac health as thoroughly explained to me by the physician.
- I acknowledge that no guarantee or assurance has been made to me as to the results of medical treatments or examinations.
- I understand that I have the right to be informed by my physician of the nature and purpose of any recommended treatment and/or testing, as well as any associated risks.
- This consent is not, in any way, to be considered an alternative to my physician's explanation(s) of treatment recommendations made by him.

Acknowledgment of Financial Responsibility

I, _____, acknowledge full responsibility for services rendered by Cardiology of Atlanta.

- I acknowledge that my insurance coverage is a contract between me, my employer (if applicable) and the insurance company. Cardiology of Atlanta is not a party to that contract. I agree that Cardiology of Atlanta will file my insurance for payment of services rendered as a courtesy, and that payment is not guaranteed. By providing them with my insurance information, I am authorizing assignment of benefits to Cardiology of Atlanta for payment. I understand that all deductible, co-insurance, and/or co-pay amounts are my responsibility, that payment of these obligations are due at the time of service, and that it is my obligation to make provisions to fulfill this responsibility.
- I understand that if an unpaid balance ages to a delinquent status, defined as older than 90 days, that the balance may be turned over to an outside collection agency and I will be responsible for all costs incurred for that collection effort, which includes a collection fee of 30% of the balance being placed in collections.
- I acknowledge that it is my responsibility to update any changes in my demographic information (address, phone number, marital status, insurance coverage, etc.) to ensure I remain actively engaged in all financial matters concerning my treatment at Cardiology of Atlanta.
- If I am uninsured at any time during my care at Cardiology of Atlanta, I understand that cash pay rates are available and are payable in full at the time of my appointment(s).

Patient/POA Signature: _____ DOB: _____

Printed Name: _____ Date: _____

COA Witness: _____ Date: _____