Patient Registration Form

Patient Information:

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

Social Security Number: _____ Preferred Pharmacy: _____

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____ Preferred Language_____

Race (optional): _____ Ethnicity (optional): ☐ Hispanic, ☐ non-Hispanic

Emergency Contact Information:

Name:_____ Relationship:_____

Phone Number:_____ or _____

Responsible Party Information: (Required if Patient is under 18 years of age)

Name:_____ Relationship:_____

Phone Number:_____ or _____

Insurance Information:

Primary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____/_____/_____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____/_____/_____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Important Payment Notice -- Signature Required:

Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for the healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if the health insurance information is provided, this in no way relieves me of my financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment: I understand that I am ultimately financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. I am responsible for paying the difference between the invoiced amount and the amount my insurance provider chooses to pay. In the event of non-payment by me of any amount due to the practice after 90 days, I agree to pay the original amount due, any collection fees of 33 and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice in the process of collecting my debt owed.

Signature of responsible party: _____ **Date:**_____

Authorization to Use or Disclose Protected Health Information

Patient Name: _____ *Date of Birth:* ____/____/____ *Home#:*_____

I, _____, understand Polaris Heart & Vascular is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations as designated below. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below by any current employee or owner of Polaris Heart & Vascular. I understand that when the information is used to disclose pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date.

My medical information may be discussed with the following person(s)

Name	Relationship	Phone

Signature: _____ ***Date:***_____

TREATMENT AND PAYMENT POLICY IN VIRGINIA

The terms "you" and "your" as used in Polaris Heart & Vascular Treatment and Payment Policy in Virginia, mean the Patient and the Patient's Guarantor, if applicable. A Guarantor is the individual who accepts financial responsibility for services rendered to a minor, incapacitated or otherwise legally dependent Patient. The Guarantor may be a family member or non-family member with legal authority to act on the Patient's behalf, including the authority to consent to medical services. By signing this form the Guarantor is informing Polaris Heart & Vascular that he/she has such authority.

Printed Name of Patient or Guarantor	**Signature of Patient or Guarantor**	**Date**
Minor Patient's Name, (Relationship to Guarantor)	**Witness Signature**	**Date**

HIPAA- Please initial the following:

_____ I (Patient/Guarantor) hereby acknowledge that I have been provided with a copy of the **Privacy Practices of *Polaris Heart & Vascular* and HIPAA Notice.**