PATIENT REGISTRATION

First Name:_____ MI:____ Last Name:_____

Email Address:_____ Date of Birth:___/___/___ Sex: M F

Address:_____ Apt:_____ City:_____ State:____ Zip:_____

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

Marital Status: S D M W Student: Not Full Time Part Time

Employer:_____

Primary Care Doctor:_____ Phone:_____

Pharmacy:_____ Cross Streets:_____&_____

Mail Delivery Pharmacy:_____ Contact Number:(_____)_____

INSURANCE INFORMATION

Primary Insurance:_____ Phone:(_____)_____
Policy Number:_____ Group Number:_____
Policy Holder:_____ Relationship:_____
Claims Address:_____ City:_____State:_____ Zip:_____

Secondary Insurance:_____ Phone:(_____)_____
Policy Number:_____ Group Number:_____
Policy Holder:_____ Relationship:_____
Claims Address:_____ City:_____ State:_____ Zip:_____

I hereby give permission to Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC to treat me as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered; and if necessary, I agree to pay all reasonable and customary collection fees and / or attorney's fees that may be incurrent due to any delinquent accounts I may have. I further more authorize payment of medical benefits directly to my physician for services rendered.

Release of Private Health Care Information

I hereby give permission for the following person(s) to contact the office on my behalf to discuss my private healthcare information with the providers/staff or billing personnel of Gilbert Cardiology:

Name:_____ Relation:_____ Phone:(_____)_____
Name:_____ Relation:_____ Phone:(_____)_____

EMERGENCY CONTACT INFORMATION:

Name:_____ Relation:_____ Phone:(_____)_____
Name:_____ Relation:_____ Phone:(_____)_____

- Patient Signature:_____ Date:_____/_____/_____

Insurance Information/Policy/Responsibility

As a patient, you are responsible for knowing your insurance policy and verifying participation. For example, you will be responsible for any charges if any of the following apply:

- Your health plan requires prior authorizations or referral by a primary care physician (PCP) before receiving services at **Gilbert Cardiology**, and you have not obtained such an authorization or referral.
- You receive services in excess of such authorization or referral.
- Your health plan determines that the services you received at **Gilbert Cardiology** are not medically necessary and /or not covered by your insurance plan.
- Your health plan coverage has lapsed or expired at the time you receive services at **Gilbert Cardiology**.
- You have chosen not to use your health plan coverage. If you are not familiar with your insurance plan coverage, we recommend you contact your carrier or plan facility.

Gilbert Cardiology will attempt to obtain referrals from the patients primary care physician (PCP) if one is required, however it is patient responsibility to make sure that referral is obtained. **Gilbert Cardiology** will also try to obtain prior authorizations for any testing that is performed in the office through the patient's insurance company. **Gilbert Cardiology** will inform the patient if the testing is *DENIED* by insurance *PRIOR* to the patient's scheduled appointment. However, it is up to the patient to determine any out of pocket cost and/or expenses for the particular testing.

Patient Name (print):_____

Patient Name (signature):_____

Date:_____

Financial Policy and Patient Responsibility

Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-workers. If you are not familiar with you plan coverage. We recommend you contact your carrier directly.
- To obtain a referral from their primary care physician and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay at the time of arrival.
- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month (or 18% per year) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- A 60 day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgemets:

I have read and understood the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard or Visa. I agree that if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

➢ _____ _____ _____

Printed Patient Name Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claim forms for me by Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC. I also authorize my insurance carriers to make payments directly to these companies.

➢ _____ _____

Signature Date

Authorization for Medical Records Request/ Release

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

You are hereby authorized to release/request any medical notes, reports, labs, operative reports and films to/from Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC.

(FOR OFFICE TO FILL OUT)

We specifically request:_____
_____
_____

I hereby release Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC and its staff from liability and all claims of nature whatsoever, pertaining to disclosure of this information.

If I have requested these records for my own personal use, I am responsible for the safe keeping of these records. Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC and its staff is not responsible if these records were to get damaged or last once given to me.

- _____
  Patient Signature/Personal Representative Signature

(FOR OFFICE TO FILL OUT)

Dr. Name:_____
Phone Number:_____
Fax Number:_____

Appointment Cancellation Policy

If you do not cancel your appointment that is scheduled with either Dr. Zaki Lababidi, or Dr. Khaled Albasha **24 hours** prior to your appointment time, you will incur a $**50** charge.

If you do need to cancel an appointment, the staff at Gilbert Cardiology will be more than happy to accommodate you.

I have read and understood the policy at Gilbert Cardiology regarding cancelled appointments.

- Printed Name:_____
- Signature:_____
- Date: _____/_____/_____

Acknowledgement of Privacy Practices

Notice of Acknowledgement of Privacy Practices:

I acknowledge that I have received, been offered, or reviewed Gilbert Cardiology's Notice of Privacy Practices.

- Patient Signature:_____ Date:_____

OR

- Personal Representative Signature:_____ Relation:_____ Date:_____

If you would like any person(s) to be able to communicate with Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP, Ala Alkhader, AGACNP-BC or office staff about your care, please include their name below. You many add or remove any person at any time.

You may discuss my care with the following person(s):

_____ _____

Name **Name**

_____ _____

Name **Name**

Advanced Beneficiary Notice (ABN)

- Patient's Name: _____
- Medicare Number: _____-_____-_____
- Authorization Period: From: _____/_____/_____ To: _____/_____/_____
  (***Or until rescinded)

"I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I also authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim of any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

- Patient's Signature:_____
- Date: _____/_____/_____