

C.A.I.
A Cardiovascular & Arrhythmia Institute

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have received the Notice of Privacy Practices of Cardiac Arrhythmia Institute, LLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement. I also understand that CAI uses an electronic medication prescription program that retrieves your previous 2 years of prescribed medication. By signing below, I give consent to view these records.

OK to leave a voice mail for test results and general information? Yes / No

Please designate one person (name, relationship and phone number) other than yourself, who can receive information on you:

x _____ Phone Number _____.

Date: _____

Signature of Patient or Patient Representative: _____

Print Patient or Patient Rep.'s Full Name: _____

Brief Description of Patient Rep's Authority: _____

For Office Use ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of Notice of Privacy Practices of A Cardiovascular and Arrhythmia Institute, LLC. However, I could not obtain the written acknowledgment because: (please check a box below)

_____ The individual refused to sign this acknowledgment

_____ Communications barrier prohibited obtaining this written acknowledgment

_____ An emergency situation prevented obtaining written acknowledgement

_____ Other (please specify)

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Records Release

To: _____

I hereby authorize: Cardiac Arrhythmia Institute, LLC

Copy or Summary of:

Concerning my illness and/or treatment during the period from:

_____ to _____

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Witness & Relationship of Witness:

**** This authorization will expire in 12 months from the date of this signature****

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Patient Registration Form

Patient: _____
SS #: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone 1: () _____ Phone 2: () _____
Employer: _____

- **Email address** to be able to access our online Patient Portal: _____
- **If active in Portal, would you like to receive billing statements through email?** ___ Yes ___ No
- **Preferred Method of Contact** (please note we will make phone calls for most communication but may use this method for other communication needs): Letter ___ Phone ___ Email ___ Fax ___
- **Marital Status:** Single ___ Married ___ Widowed ___ Divorced ___
- **Race:** White ___ Black or African American ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Undetermined (includes any race not listed or if you decline to answer) ___
- **Ethnicity:** Latino or Hispanic ___ Not Hispanic or Latino ___ Other or Undetermined (includes any race not listed or if you decline to answer) ___
- **Gender:** Male ___ Female ___
- **Language:** _____

Referred By : _____
Primary Care Physician: _____ Phone #: () _____
Emergency Contact: _____
Emergency Phone #: () _____

Insured Party Information (If other than yourself)

Name of Insured: _____ Phone: _____
Address of Insured: _____ City/State/Zip: _____
Employer of insured: _____
Date of Birth: _____ SS#: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Address: _____ City/State/Zip: _____
Subscriber Name: _____ Relationship to Patient: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Address: _____ City/State/Zip: _____

Authorization & Assignment

I hereby authorize Cardiovascular and Arrhythmia Institute, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. I hereby authorize direct payment of medical benefits to Cardiac Arrhythmia Institute, LLC, for services rendered. I understand that I am financially responsible for any balances not covered by my insurance. If this account is not paid promptly, and office deems it necessary to utilize a collection service, I agree to all reasonable collection fees and/or legal fees, plus the present balance of the delinquent account.

PATIENT SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY (if other than patient): _____ DATE: _____

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Policy and Procedures of CAI

We would like to take this opportunity to welcome you to our office. The following document will outline our policies and procedures relating to our financial policy. Please take some time and read this document.

HEALTHCARE REQUIREMENTS:

The Institute specializes in your complete Cardiovascular Care, including Electrophysiology and heart arrhythmias. We believe in providing you with the best possible care and working as a team with your family physician, internists, other cardiologists and/or any other specialists to help you with the latest care in healthy living.

PAYMENT AT THE TIME SERVICE IS RENDERED: _____ initials

Payment is required at the time services are rendered. We would appreciate your co-pays, deductibles, and/or patient non-insured portion at the time of the visits, if we participate with your insurance plan. This policy allows us to balance your account to zero when the insurance check arrives and saves you from receiving numerous monthly statements. We accept cash, personal checks, and MasterCard or Visa. For all returned checks an additional \$25 fee will be assessed and incurred by the writer per check.

BILLING PROCEDURES: _____ initials

As you visit our office requesting medical care, you undertake a personal obligation and responsibility for your account. All statements are mailed out monthly. We ask that you pay balances off monthly, (unless other arrangements have been made), and we regard any account over 90 days old as a matter of collection.

COLLECTION PROCESS: _____ initials

If any account does advance to collection and/ or litigation, the patient is financially responsible for all costs that might be incurred in collection said account, i.e. attorney fees, court costs, filing fees etc.

INSURANCE REFERRALS:

For any contracted insurance plans that require a referral form, we must ask that the referral form be brought in with you at the time of the appointment. We will not await the referral by mail. If we do not have the referral form at the time of your appointment, your appointment will be rescheduled unless you are willing to pay in full that day.

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Policy and Procedures of CAI- Continued

TREATMENT ESTIMATES:

New patient visits take more time than return visits, therefore the charges are typically higher. You may feel free to discuss our fees with the billing office at any time. In addition, other testing may need to be performed; therefore the final charges may be more than what was originally estimated.

ADDRESS AND INSURANCE CHANGES:

Please keep us informed of address, telephone number, employment, or insurance changes.

INTEGRITY AGREEMENT:

Both parties desire to have a method of resolving discomfort, misunderstanding, or disputes. If any of these previously mentioned occur, please bring it to our attention privately, quickly, and in a friendly manner. We agree to resolve these matters using the communication, mediation, and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement. (This in no way relinquishes your possibilities of seeking legal counsel.)

SPECIAL NEEDS:

We are here to help you. If you have special needs or circumstances that may require a payment plan, please feel free to discuss this with us as early as possible.

CANCELLATION OF APPOINTMENTS: _____ initials

We require a 24 hour cancellation notice of all scheduled appointments. Any appointments not cancelled within a 24 hour time frame will be subject to a cancellation fee.

Thank you for taking the time to read this policy and procedures statement. We hope that it answers any questions that you may have regarding the Institute's financial policies.

Patient's Declaration:

I have read and understand this policy statement. I understand that I am financially responsible for charges incurred and I authorize my insurance carrier to pay benefits to CAI Cardiac Arrhythmia Institute, LLC. All of my questions and concerns have been answered.

Signed _____
(Name)

Signed _____
(Guardian- if applicable)

Date: _____

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Advance Directive

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. You can write an advance directive in several ways:

- Use a form if provided by your doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized and copies should be given to your family and your doctor.

It is our policy to have each of our patient's Advance Directives reviewed and noted in the chart annually. Please choose from the list below and check what pertains to you.

- Discussed- No decision made
- You have a Living Will on file
- Do Not Resuscitate- please provide a copy for us to have on file
- Power of Attorney- please provide a copy for us to have on file
- Specific Advance Directive- please provide a copy for us to have on file

Patient signature

Date

Witness signature (employee of C.A.I.)

Date