Cardiac EP Consultants, S.C.
PATIENT INFO, AGREEMENTS & AUTHORIZATIONS

Name (Last, First, Middle) ______________________________ Date of Birth ________________

SSN ________________ Race* ____________________ Ethnicity **________________________

Preferred method of contact : **Phone** (Alt/ Cell/ Day/ Home/ 2nd Home/ Work) OR **Mail** (Home/2nd Home) OR **Email**:

________________________________________________________ Language ________________

Write "same" if there has been no change in the following information since your last Office visit:

Street Address __________________________ City ___________ State_____ Zip Code________

Home Phone___________________ Work Phone________________ Cell Phone____________________

**Email** : ______________________________________ (Needed to set up on line access to your health info)

Emergency Contact Name ____________________________ Phone Number _______________________

Emergency Contact Relation _________________________

Primary Care Physician_____________________________ Phone Number _______________________

Referring Physician _______________________________ Phone Number _______________________

IF POLICY HOLDER *IS NOT* THE PATIENT, PLEASE PROVIDE THE FOLLOWING:

Insured's Name____________________________ Relationship to Patient __________________________

Date of Birth ___________SSN ____________ Home Phone____________ Alternate Phone____________

*American Indian or Alaska native/Asian/Black of African American/More than one race/ Native Hawaiian or other Pacific Islander/ White/ Other ** Hispanic or Latino/Not Hispanic or Latino/ Unknown or Unreported

**CONSENT FOR TREATMENT**: I hereby authorize Cardiac EP Consultants, S.C. and its appropriate personnel, to perform upon me, or the named patient, appropriate assessment and treatment.

**RELEASE OF INFORMATION** I further authorize Cardiac EP Consultants, S.C. to release to appropriate agencies such as insurance companies or other physicians involved in my care all the information acquired in the course of my or the above named patient's, examination and treatment.

**ASSIGNMENT OF BENEFITS**: I direct and assign payment from my Insurance Company to Cardiac EP Consultants, S.C. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for any charges not covered by my insurance company including all co-pays, deductibles or any other fees not covered by my insurance. I understand that if my balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees.

**PRE-CERTIFICATION**: I also understand that I am responsible for notifying my insurance company, if required, to obtain authorization before service is provided. I understand that if I do not pre-certify my treatment, obtain a referral &/or fail to meet the requirements of my insurance company, it may cause a reduction or loss of paid benefits. I will be liable for that loss or reduction in paid benefits.

**PHONE CONTACT**:

I authorize Cardiac EP Consultants and it's staff to leave limited protected health information on my phone.

**I understand that I am to submit a written request regarding any restrictions.**

**I have been offered &/or received the Notice of Privacy Practices (HIPAA).**

SIGNATURE____________________________________ DATE______________________