

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

Name (Last, First, Middle) _____		Date of Birth _____	
SSN _____	Race* _____	Ethnicity ** _____	
Preferred method of contact : <b>Phone</b> (Alt/ Cell/ Day/ Home/ 2 <sup>nd</sup> Home/ Work) OR <b>Mail</b> (Home/2 <sup>nd</sup> Home) OR <b>Email</b> : _____			
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 _____	
<b>Email</b> : _____ (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 _____	
<b>IF POLICY HOLDER IS NOT THE PATIENT, PLEASE PROVIDE THE FOLLOWING:</b>			
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 \_\_\_\_\_