Atlanta Cardiology Consultants, P.C.
Thomas S. Backer, M.D., F.A.C.C. / Katie Steffen, MMSC PA-C

PATIENT HISTORY

IDENTIFICATION

Name: ____________ Age: ______ Date: ____________

Referred By: ____________

EMAIL: ____________

MAJOR COMPLAINT OR PROBLEM (Reason for visit)

____

____

CURRENT MEDICATIONS	DRUG ALLERGIES

HOSPITALIZATIONS OR SURGERIES

DATE	REASON	DATE	REASON

PAST MEDICAL HISTORY (Approximate Age of Onset)

Heart Attack ____	Hypertension ____	Tuberculosis ____	Liver Disease ____
Angina ____	Diabetes ____	Asthma ____	Frequent Indigestion ____
Heart Failure ____	High Cholesterol ____	Emphysema ____	Blood in Stool ____
Heart Murmur ____	Stroke ____	Chronic Bronchitis ____	Cancer ____
Chest Pain ____	Seizure/Convulsion ____	Pneumonia ____	AIDS/HIV ____
Shortness of Breath ____	Phlebitis ____	Pulmonary Embolism ____	Thyroid Disease ____
Palpitations ____	Kidney Stones ____	Chronic Cough ____	Anemia ____
Dizziness/Faintness ____	Kidney Infection ____	Ulcers ____	Gout ____
Loss of Consciousness ____	Kidney Disease ____	Gall Bladder ____	Psychiatric Treatment ____
Rheumatic Fever ____		Hepatitis ____	

FAMILY HISTORY

		Age	Illness	Cause of Death
Father	Alive/Dead			
Mother	Alive/Dead			
Brothers/Sisters	Alive/Dead			

HABITS

Smoking — Packs/Day ______ How Long ______ When Stopped ______

Alcohol — Estimated Amount ____________

Caffeine — Estimated Amount (Coffee, Tea, Soft Drinks) ____________

Diet — Special Diets (Cholesterol, Diabetic, Salt) ____________

Exercise ____________

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PATIENT INFORMATION FORM

MARITAL STATUS
CIRCLCE ONE
S M D W

PATIENT NAME:____ BIRTHDATE:_____________________________

ADDRESS:____

HOME PHONE:________________________ CELL PHONE:_________________________ SOCIAL SECURITY:________________________

EMPLOYER:___________________________________ ADDRESS:____

SPOUSE'S NAME__________________________ S.S.#___________________DOB_______________PHONE_________________________

(If spouse is policy holder)

RELATIVE OR FRIEND WE CAN CONTACT IN CASE OF AN EMERGENCY:

NAME: ____ ADDRESS____

HOME PHONE: _____________________________________ WORK PHONE: _____________________________________

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY REFERRING PHYSICIAN

REFERRING PHYSICIAN____ X____

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A PRE-CERTIFICATION OR 2ND OPINION BEFORE ENTERING THE HOSPITAL, YOU MUST CONTACT YOUR REPRESENTATIVE TO MAKE ARRANGEMENTS. IF YOU DO NOT IT COULD MEAN THAT ALL OR A PORTION OF YOUR MEDICAL BILL WOULD NOT BE REIMBURSED TO YOU BY YOUR INSURANCE COMPANY.

PRIMARY INSURANCE-COMPANY NAME: ____

SECONDARY INSURANCE-COMPANY NAME: ____

PHARMACY PREFERENCE:

NAME:____

LOCATION:____

PHONE NUMBE____

PATIENT PORTAL ACCESS: **DECLINE** ☐

PLEASE PROVIDE AN EMAIL ADDRESS FOR ACCESS TO OUR SECURE PATIENT PORTAL

EMAIL ADDRESS: ____

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OUR FINANCIAL POLICY

I acknowledge my financial responsibility to Atlanta Cardiology Consultants, P.C. for professional services rendered. I authorize Atlanta Cardiology Consultants, P.C. to furnish information to my insurance carrier concerning my health and/or treatments. I understand that Atlanta Cardiology Consultants, P.C. may file my insurance claim, and that this will be done in good faith and using appropriate diagnosis codes. I further understand that once this claim has been filed these codes can only be changed if there was an error in posting. Under no circumstances will CPT codes or diagnosis codes be changed at the patients request, as this may constitute fraud. All coding changes have to be approved by the physician and have to support medical guidelines.

Please be advised that all procedures performed at Atlanta Cardiology Consultants, P.C. are subject to the requirements of your insurance company. It is the patients' responsibility to understand the provisions of their insurance carrier. Essentially your insurance coverage is an agreement between you and your insurance carrier. We will help expedite your claim, but you are ultimately responsible for timely payment on your account.

You must realize:

- It is solely the patient's responsibility to confirm participation of Thomas S. Backer, M.D. / Katie Steffen, MMSC PA-C / Atlanta Cardiology Consultants, P.C. with your insurance plan.
- **It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. If the insurance requires referral, authorization, preauthorization or precertification prior to being seen or prior to having a procedure done, it is the responsibility of the patient to obtain such. NONPAYMENT OF SERVICES FOR FAILURE TO OBTAIN AN AUTHORIZATION, PREAUTHORIZATION REFERRAL, OR PRECERTIFICATION WILL BE THE RESPONSIBILTY OF THE PATIENT.**
- **It is your responsibility to keep us updated with your correct insurance information.**
- **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
- You are responsible for any and all co-payments, deductibles, and coinsurance as required by your insurance plan.
- Co-payments are due at the time of service; a $20.00 service fee will be charged in addition to your co-payment if the co-payment is not paid at the time of service.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* ten (10) business days of receipt of your bill.
- If we do not participate in your insurance plan, payment in **FULL** is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- Self-pay patients are expected to pay for services in **FULL** at the time of the visit or when services are rendered
- Your insurance is a contact between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and in some

instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

- Prior balances must be paid before your next scheduled appointment.
- If you participate with a high deductible health plan, be prepared to pay your deductible amount prior to your appointment, we will collect deductible's prior to check in.
- We accept cash, checks, Visa and MasterCard, and debit cards.

Medicare:

Our office accepts Medicare assignment. **We do not file secondary insurance.** Most secondary insurance carriers will automatically crossover from Medicare, it is the patient's responsibility to contact their secondary insurance carrier and request that this “automatic crossover” be setup.

Please Note:

Interest of 1% per month will be charged on all patient due balances that are 60 days past due until the balance is paid in full.

A fee of $25.00 will be charged to patient account for all returned checks, plus any bank fees incurred.

We require 48-hour notice for canceling any appointments. A fee of $50.00 will be charged to patient account for any cancellations with less than 48-hours' notice. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in your dismissal from the practice.

Collections:

If necessary, any outstanding balance **(more than 60 days past due)** may be turned over to a collection agency or attorney at law for collection purposes. In such circumstances, the patient is fully responsible for payment of all remaining balances, legal or collection fees, plus interest as provided in O.C.G.A. 7-4-16.

Thank you for your cooperation,

____
Print Name

____ ________________________________
Responsible Party Signature Date

Atlanta Cardiology Consultants, P.C.

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Acknowledgement of Receipt of Privacy Practices

I, ____, have received or been given an opportunity to review a copy of Atlanta Cardiology Consultants, P.C. Notice of Privacy Practices.

____ ______________________________

Signature Date

Patient Agreement for Communications

I understand that as part of my health care Atlanta Cardiology Consultants, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of a special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I understand that Atlanta Cardiology Consults, P.C. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

I authorize Atlanta Cardiology Consultants, P.C. to speak with the following person/s and release information on my behalf:

____

____

IN ORDER TO KEEP OUR CHARGES AS LOW AS POSSIBLE, WE EXPECT PAYMENT AT TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and acknowledge receiving and reading a copy of the Financial Policy. I authorize payment of benefits to Atlanta Cardiology Consultants, P.C. To release any medical or other information necessary to process insurance claims. I further authorize photocopies of this form to be as valid as the original.

X____DATE: ______________________

I authorize Atlanta Cardiology Consultants, P.C. To release my records for the purpose of treatment, payment, and healthcare operations.

X____DATE: ______________________