CARDIOVASCULAR CLINIC
of
NORTH GEORGIA

CVCNG

Dr. Salman Ashfaq, MD, FACC, FSCAI
Dr. Saurabh Dhawan, MD, FACC
Dr. Hannah Asghar, MD,FACC
Dr. Shelia Woodhouse, MD, FACC

By signing this form, I authorize the Cardiovascular clinic of North Georgia to obtain records from facility listed below.

Valid for one year from date of Signature

Name: ______________________________

DOB: ______________________________

Social Security: ______________________________

Address: ______________________________

Date: ______________________________

Signature: ______________________________

Release from:

Facility/ Doctor: ______________________________

Address: ______________________________

Phone number: ______________________________

Fax number: ______________________________

Please release records to:
Cardiovascular Clinic of North Georgia
P.O. Box 908240
Gainesville, GA 30501

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Registration Form

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle intial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(preferred name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Mailing address:	City:	State:

Zip Code:	Social Security Number:	Phone Number:	Email:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Pharmacy Name & Location:

Per the federal Government we are asked to gather the following information:

Race (circle one) American Indian Alaskan Asian Black/African American Hawaiian/Pacific Islander White Other Decline

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Decline

INSURANCE INFORMATION

Policy Holder:	Birth date: / /	Social Security Number:	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Does this patient have any additional insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cardiovascular clinic of north Georgia or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Medication List

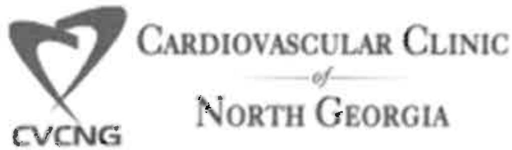
Name: ______________________________ DOB:____________________

Allergies: ____

Please include any over the counter supplements that you currently take

Name:	Dosage:

Office Locations:
1287 Sims street Gainesville, GA 30501 | 4700 Nelson Brogdon Blvd. Ste. 200 Buford, GA 30518
1515 River Place Ste. 140 Braselton, GA 30517 | 638 Historic Hwy 441 N. Ste C Demorest, GA 30535
771 Old Norcross Road, Ste 105 Lawrenceville, GA 30046 | 6335 Hospital Parkway Ste. 305 Johns Creek, Georgia 30097



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HIPAA Acknowledgement:

I understand that under the Health Insurance Portability & Accountability Act of 1996.I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have read and understand the CVCNG Notice of Privacy Practices. I understand that this practice has the rights to change its Notice of Privacy Practices and that I may contact the practice at any given time to obtain a copy.

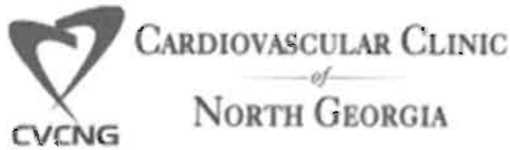
I authorize CVCNG to release and/or obtain my records to/from other physicians for the purpose of continuity of care.

____

Signature of patient/patient Representative Relationship Date

Financial Policy & Assignment of Benefits:

- Copayments for services are required at the time of registration. Failure to pay your copayment at the time of service may result in a billing/statement fee of $10.00. Please be advised that we are contractually obligated by your insurance carrier to collect your copayment at the time of service.
- We will process and file your insurance claims for services. The balance of your charges will be billed to you. Payment in full of the patient portion will be expected with receipt of your statement. You will receive two billing statements regarding your balance.
- 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 and you may be responsible for the balance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless prior arrangements have been made.
-



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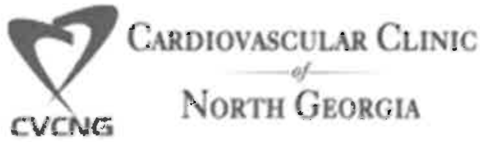
Financial Policy & Assignment of Benefits:
(Continued)

- If you do not have insurance, please ask to speak with the practice manager to review our payment options. We offer a 50% discount on your services if you pay on the same day services are rendered. If you cannot pay at the time of service, we offer a 30% discount and we will be happy to put a payment arrangement in place for you that meets our established practice policy.
- For hospital charges, we offer a 50% discount on services if paid in full upon receipt of statement. If you cannot pay upon receipt of statement, we offer a 30% discount on services and we will be happy to put a payment arrangement in place for you that meets our established practice policy.
- Returned checks are subject to a handling fee of $30.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.
- Cancellation policies are set forth to ensure all patients are seen in a timely manner. If for any reason you cannot keep your appointment, we ask that you cancel at least 24 hours in advance. If you are scheduled for a test and do not cancel at least 24 hours in advance of your appointment time, a cancellation fee of $100 will be assessed to your account

____

Signature of Patient/Patient Representative Relationship Date



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Authorization to release protected health information:

NOTE: You have the right to request a restriction on your protected health information (PHI) at any time.

Patients may request that we release their protected health information to family, friends, or physicians. If you request this right, we are required to have a completed authorization Prior to releasing your PHI. If you wish for someone to have access to your PHI please complete the authorization.

I authorize the individuals below access to my PHI over the telephone. This authorization is effective until such time as you revoke or terminate this authorization.

Name ______________________ **Relation** ______________________

Name ______________________ **Relation** ______________________

If you do not wish to disclose information to anyone please indicate by checking box below.

☐ Do not disclose information

If you would like for our office to release any protected health information to another physician please complete below.

Physician Name & Location ______________________

Physician Name & Location ______________________

Signature is acknowledgement that you have read and understand the implications of this authorization to release your protected health information to others designated above.

Print Name ______________________ **DOB** ______________________

Signature ______________________ **Date** ______________________