Eastern Carolina Cardiovascular, PA

REGISTRATION INFORMATION

Please Print Clearly

Name: ____
(Last Name) (First Name) (Initial)

Sex: ❑ M ❑ F Age: _______

Birthdate: __________________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security Number: _______________________ Spouse's Social Security Number: ____________________

*Doctor ____

Who is responsible for this account? ______________________________ Relationship to Patient: ______________

Responsible Party (if a minor): ____

Home Address: ____

City: ______________________________ State: ___________________ Zip: ______________

Home Phone: ______________________________ Business Phone: ____________________

Do you have Medical Insurance: ❑ No ❑ Yes If Yes ⇨

Name of Primary Insurer: ____

Address to submit claims: ____

Subscriber # ______________________________ Group # _____________ Contact # ______________

Name of Secondary Insurer: ____

Address to submit claims: ____

❑ Medicare ❑ Medicaid

In case of emergency, who should be notified? ___________________________ Phone: ______________

Patient Employed By: ____

Business Address: ____

Occupation: ____

How did you hear about our Practice: ____

Assignment of Benefits and Release of Information

I, the undersigned, assign directly to Eastern Carolina Cardiovascular, PA all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. If for any reason my account is turned over to a collection agency, I understand that additional fees may be assessed and that I agree to pay those fees. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured: ______________________________ Date: ______________________________

Privacy Practices Document

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: ___________________________________ Birthdate: _______________
(Print Name)

Signature: ______________________________________ Date: ___________________

TO BE COMPLETED BY THE FRONT DESK

Written acknowledgment could not be documented due to:

________ Patient refused to sign.

________ Personal representation not available to sign.

________ Language, Communication, or effect of disability impeded acknowledgment.

________ Emergency care impeded acknowledgment.

________ Other, Please specify ____

Eastern Carolina Cardiovascular, PA

Lindsey L. White, M.D., F.A.C.C. Richard F. Wessel, M.D., F.A.C.C. Jose Jacob, M.D., F.A.C.C.
Michael J. Bratton, MS, P.A.-C Billee Payne, FNP-C Margaret Zirpoli, FNP-C Kimberly Caesar, MS, P.A.-C Edward J. Healy, P.A.-C

REQUEST FOR ACCESS TO MEDICAL RECORDS

Date ______________________________

Patient's Name ______________________________

Social Security # ______________________________ DOB ______________________________

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

By signing this document, I give permission for (my family members, other relatives,close personal friends) the people below to have access to my medical records and billing information.

____

Patient's Signature

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

☐ ***I do not want any family members, relatives or close personal friends to have access to my medical records or billing information.***

1134 N. Road St, Bldg 9
Elizabeth City, NC 27909
252-331-1100
Fax 252-335-2393

222 Virginia Road
Edenton, NC 27932
252-482-5600
Fax 252-482-0339

4810 S. Croatan Hwy, Ste. 200
Nags Head, NC 27959
252-441-2444
Fax 252-441-8910

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Robin Adami, ANP-C

Patient Consent Agreement for Chronic Care Services

Medicare now offers a new benefit for patients with multiple chronic diseases, and by consenting to this Agreement, you designate your provider at Eastern Carolina Cardiovascular, to provide chronic care management (CCM) services per the new rule.

Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don't have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at last 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Provider Chronic Care Services

As past of this new benefit, you Provider agrees to make available the following services:

1. 24/7 access to a healthcare provider to address your acute chronic care needs.
2. Use of certified EHR software to document your care.
3. Provide a written or electronic version of you care plan.
4. Perform medication reviews and oversight.
5. Assist in the management of transitions of care from one provider to another.

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Consent Terms

By signing this Agreement, you agree to the following terms required by Medicare:

1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM services to you during a thirty (30)-day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Services.
5. You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Beneficiary or Caregiver

Signature:______________________________ Print Name:______________________________

Date: ____________________________