

Eastern Carolina Cardiovascular, PA

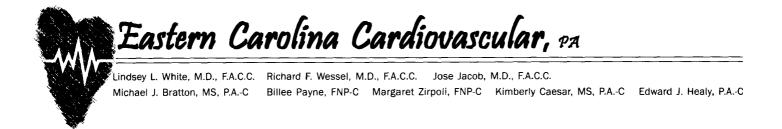
REGISTRATION INFORMATION

Please Print Clearly

Name:		
(Last Name) Sex: M F Age:	(First Name)	(Initial)
	☑ Married ☑ Widowed ☑ Sepa	rated Diverged
_	·	
Social Security Number:		
*Doctor		
Who is responsible for this account?		
Responsible Party (if a minor):		
Home Address:		
City:	State:	Zip:
Home Phone: Business Phone:		
Do you have Medical Insurance: $\ \ \Box$ No $\ \ \ \Box$ 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	d?	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	e 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 COMPLE	ETED BY THE FRONT DESK	
Written acknowledgment could not be	e documented due to:	
Patient refused to sign.		
Personal representation not available to sign.		
Language, Communication, or effect of disability impeded acknowledgment.		
Emergency care impeded a	cknowledgment.	
Other, Please specify		



REQUEST FOR ACCESS TO MEDICAL RECORDS

Date	_
Patient's Name	
Social Security #	DOB
I understand that, under the Health Insurance Portability & Acc privacy regarding my protected health information.	countability Act of 1996 (HIPAA), I have certain rights to
By signing this document, I give permission for (my family mento have access to my medical records and billing information.	nbers, other relatives,close personal friends) the people below
Patient's Signature	
Name	Relationship to Patient
	ers, relatives or close personal edical records or billing information.



Eastern Carolina Cardiovascular, PA

Lindsey L. White, M.D., FACC Billie Payne, FNP-C Kim Chalot, FNP-C Alan Maniet, DO, FAAIM Kimberly Ceasar, MS, P.A.-C Michael J. Bratton, MS, P.A.-C

Jose Jacob, M.D., FACC Edward Healy, P.A.-C Amparo Halecki, ANP-C John Adami, M.D., FACC 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:	

www.easterncarolinacardiovascular.com