Los Angeles Cardiology Associates

A Medical Group

Patient Registration Form

Please Provide Insurance Card for Verification

DATE: ______________ LACA #: ______________________ BUS OFF: ☐

NAME OF PATIENT: ____
LAST FIRST M.I.

SEX: M / F AGE: _____ **DATE OF BIRTH**: ____________ SOC. SECURITY#: ______________

DRIVERS LICENSE #: __________________________ STATE: ________ MARITAL STATUS: ________

HOME ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ______

HOME TELEPHONE: __________________________ DAYTIME NUMBER: ______________________

CELL: __________________________ EMAIL: ______________________________

EMPLOYER: __________________________ OCCUPATION: __________________________

EMPLOYER ADDRESS ______________________ CITY: ______________ STATE: ______ ZIP: ______

SPOUSE NAME: ________________ **DATE OF BIRTH**: ________ SPOUSE SOC. SECURITY# : ____________

SPOUSE EMPLOYER: ____________________ SPOUSE WORK PHONE: __________________________

REFERRING PHYSICIAN: ______________________________ PHONE: ______________________

PCP: ______________________________ PHONE: ______________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP TO PATIENT: ______________________

HOME TEL.: __________________ WORK TEL.: __________________ CELL: ______________________

PRIMARY INSURANCE: ______________________ NAME OF INSURED: ☐ SELF OTHER: ______________

ID#: ____________________ GRP#: ______________________ POLICY #: ______________________

SECONDARY INSURANCE: ______________________ NAME OF INSURED: ☐ SELF OTHER: ______________

ID#: ____________________ GRP#: ______________________ POLICY #: ______________________

DO YOU BELONG TO: ☐ MEDICARE ☐ MEDI-CAL ☐ MEDICARE/HMO ☐ MEDI-CAL/HMO ☐ HMO ☐ PPO

I hereby authorize payment of my medical and surgical insurance benefits to Los Angeles Cardiology Associates. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Los Angeles Cardiology Associates. I authorize Los Angeles Cardiology Associates to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Patient Signature: ______________________________________ Date: ______________

Los Angeles Cardiology Associates

In general the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number that you have provided us on your patient sheet.

Home Telephone (____)____________________
[ ] Okay to leave message with detailed information.
[ ] Leave message with call back number only

Cellular Telephone (___)_________________
[ ] Okay to leave message with detailed information.
[ ] Leave message with call back number only

Work Telephone (____)______________________
[ ] Okay to leave message with detailed information
[ ] Leave message with call back number only
[ ] Okay to fax to (____)______________________.

Written Communication
[ ] Okay to mail to my home address
[ ] Please mail to another address: ____

The Privacy Rule Generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for used or disclosures made pursuant to an authorization requested by the individual.

Record of Disclosures of Protected Health Information

I, _________________________________authorize the office of Los Angeles Cardiology Associates, to contact the following person(s) in regard to my medical information.

______________________________	____________________________
Name/relationship	Telephone Number
______________________________	____________________________
Name/relationship	Telephone Number
___________________________________	___________________________________
Patient Signature	Patient Name
___________________________________	___________________________________
Birth date	Date