CHICAGO
HEART & VASCULAR
SPECIALISTS

Patient Registration Form

PATIENT DEMOGRAPHICS			
Last Name		**First Name**	**Middle Initial**
Address			**Date of Birth**
City	**State**	**Zip Code**	**Sex** ☐ Male ☐ Female ☐ Other
Home Phone	**Cell Phone**		**Work Phone**
Social Security Number		**Email Address**	
Marital Status ☐ Single ☐ Married ☐ Other			
Race/Ethnicity ☐ Caucasian (White) ☐ Black/African American ☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Native American/Alaskan native ☐ Other			
Preferred Method of Contact: ☐ Email ☐ Phone ☐ Text message (Mark all that apply)			

RESPONSIBLE PARTY	
AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY	
Responsible Party Signature X ______________________________	**Today's Date**

PRIMARY CARE PHYSICIAN	
Name	
Address	**Telephone**
	Fax

EMERGENCY CONTACT		
Name	**Relationship**	**Phone number**

PAYMENT OF BENEFITS	MEDICAL RELEASE OF AUTHORIZATION
I authorize payments of benefits, as determined by the Company, directly to the physician ☐ Yes ☐ No	Insured Party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance

I understand that unless I have checked Yes above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.		company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.	
Signature X__________________________	Date	Signature X___________________________	Date

Chicago Heart & Vascular Specialists
CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

____ ______________________________

PATIENT'S NAME *DATE OF BIRTH*

Notice to Patient:

By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed below. Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to disclose my health care information with the person or persons listed below.

____ ______________________

Patient's Signature or Signature of Patient's Representative *Date*

____ ______________________

Printed Name of Patient's Representative *Relationship to Patient*

FOR OFFICE USE ONLY:

Name of Practice: Chicago Heart & Vascular Specialists

Privacy Officer's Signature or Practice Representative: ______________________________

Date: ________________________________

Chicago Heart & Vascular Specialists
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print patient name here

____
Signature

____
Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

____________________________ ____________________________

____________________________ ____________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ We were not able to communicate with the patient.

☐ Other (please provide specific details)

____

____

________________________________ ____________________
Employee signature *Date*