CARDIOLOGY SPECIALISTS OF ACADIANA
315 Rue Louis XIV, Lafayette, LA 70508 • P(337)269-9777 • F(337)269-0244

Patient Demographics:

Full Legal Name: _____

DOB: _____ Social Security #: _____

Gender: _____ Male _____ Female

Race: _____ Afr American _____ Asian _____ Caucasian
_____ Hispanic _____ Other _____ Decline

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Mobile Ph #: (_____)_____

Home Ph #: (_____)_____

Mailing Address: _____

Email Address: _____

Emergency Contact: _____

Emergency Ph#: (_____)_____

Pharmacy: _____

Pharmacy Ph #: (_____)_____

PCP/Family Doctor: _____(_____)_____

Referring Doctor & Ph#: _____(_____)_____

Nursing Home & Ph#: _____(_____)_____

Home Health & Ph#: _____(_____)_____

If minor, Parent Name: _____

Parent Ph#: (_____)_____

If different, Parent Address: _____

If different, Ins Policyholder: _____

Policyholder DOB: _____

Relation to Patient: _____

Signature: _____

Date: _____

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Patient Name:_____ **DOB:** _____

Financial Policy, Assignment of Benefits & Ownership Disclosure

I. Financial Policy:
I will provide this office with the correct information to bill my insurance as well any changes to my address, telephone numbers, etc. I understand that failure to provide the correct information at the time of service may result in me being charged directly for the services rendered. I acknowledge that my medical insurance coverage is a contract between me and my insurance carrier. My insurance is being billed as a service to me, and it is my responsibility to determine whether my insurance considers my physician an in-network provider as I am responsible for any out-of-network charges. I understand that I must pay my co-payment on the day of the appointment, or the appointment may be rescheduled. I also understand that I am responsible for the entire charge when my insurance carrier determines the medical care received to be a "non-covered" service. Even though my insurance carrier may not pay for these services, I am advising my physician and this office to proceed. Any balance of charges will be paid to this office after an Explanation of Benefits (EOB) is issued from my insurance carrier. I am ultimately responsible for any outstanding balance on the account. If I am unable to pay the balance in full, I will contact the billing department for payment plan arrangements. I understand that should my account become past due, it will be turned over to a collection agency, and my future appointments will be canceled until the balance is paid in full. I agree to provide 24-hour cancellation notice for any appointment that I cannot attend. I understand that my failure to do so may result in a no-show fee of up to $150 for each appointment for which I do not provide prior cancellation. If my service is related to Worker's Compensation, I shall not be required to pay anything until my insurance carrier processes the claim for the services provided. Prior to service rendered, I agree to provide my personal health insurance information in case the WC carrier denies payment. If I do not have other insurance, I acknowledge that I am responsible for payment. Self-pay patients are expected to pay in full at the time of service, or the appointment will be rescheduled.
If the patient is a minor, then I, as the minor's parent/legal guardian, am guaranteeing payment on the account as outlined above.

II. Assignment of Benefits: I hereby grant lien rights and assign to Cardiology Specialists of Acadiana, Drs Rehan Ali, Y Jeffrey Chen, David Daly Jr, James Dobbs, Kian Ehsan, Joseph Kowalski, Jon Leleux, Stephen Simpson, and/or Eric Thomassee (herein after referred to as "Physicians") any and all rights and benefits I have or may have with respect to any reimbursement they may be entitled to under my current insurance policy(ies) as payment toward the total charges for the services rendered to me. This is a direct assignment of my rights and benefits under such policy(ies) for the services I received by these "Physicians". This payment will not exceed my indebtedness to either of them. I agree to pay, without delay, any and all outstanding balances remaining on my account after my insurance carrier makes its payment. If my insurance carrier will not pay the "Physicians" directly, I agree that when I receive the reimbursement check from my insurance carrier, I will then, without delay, use that money to pay them for any and all outstanding balances remaining on my account relating to the services I received.
A photocopy of this Assignment shall be considered as effective and valid as the original on file. I authorize these "Physicians" to initiate a complaint to the insurance commissioner for any reason on my behalf. I understand that they are not required to do so.

III. Ownership Disclosure Statement: In compliance with 42 CFR, I understand that members of Cardiology Specialists of Acadiana, LLC, have ownership interest in the Heart Hospital of Lafayette, or other outpatient facilities to which I may be referred. I understand that I have an opportunity to ask questions and to discuss treatment options at other facilities.

I have read, understood and agreed to the terms of this document. All my questions or concerns have been answered to my satisfaction prior to signing below.

_____ _____
Patient/Legal Representative Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

Introduction: We are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information ("PHI"). This Notice is effective April 14, 2003, and applies to all PHI as defined by federal regulations.

Understanding Your Medical Record/Health Information: Each time you visit our office, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, means of communication with other health professionals involved in your care, a legal document outlining and describing the care you receive, a tool that you, or another payer (your insurance company) will use to verify that services were actually provided, an education tool for medical health providers, a source for medical research, a basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards, a source of data for planning and/or marketing, a tool that we can reference to ensure the highest quality of care and patient satisfaction. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

Your Rights: You have certain rights under the federal privacy standards. These include: the right to request restrictions on the use and disclosure of your PHI, the right to receive confidential communications concerning your medical condition and treatment; the right to inspect and copy your PHI; the right to amend or submit corrections to your protected health information; the right to receive an accounting of how and to whom your protected health information has been disclosed; the right to receive a printed copy of this notice.

Our Responsibilities: We are required to maintain the privacy of your health information, provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of the Notice, notify you if we are unable to agree on a requested restriction, accommodate reasonable request you may have regarding communication of health information via alternative means and/or locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all PHI that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization.

How We May Use and/or Disclose Your Health Information:

We will use your information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service(s) rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support he day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

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Business Associates: In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family: Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives or any other person that is involved in your care or that you have authorized to receive this information. A HIPAA Authorization completed by you shall be retained on file. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research, Teaching, Training: We may use your information for the purpose of research, teaching and training.

Healthcare Oversight: Federal law require us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are a brief message that may be left on your answering machine. If you don't approve of these methods, or if you prefer alternative methods, please inform the receptionist.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

For more information or to report a problem, please contact Administrator, Cardiology Specialists of Acadiana, LLC, PO Box 81398, Lafayette, LA 70598; 337-269-9777

If you believe your privacy rights have been violated, please contact the aforementioned practice privacy official or you may file a complaint with the Office for Civil Rights, US Dept of Health and Human Services. There will be no retaliation for filing a complaint with either party. The address for the Office for Civil Rights, US Dept of Health and Human Services, 200 Independence Ave, SW, Rom 509F, HHH Bldg, Washington, DC 20201.

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Patient Name:_____ **DOB:** _____

HIPAA AUTHORIZATION

Health information collected or received about me may be disclosed to the following persons (info provided on each person will be used for validation purposes):

Name	Relation	DOB	Phone #

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided.

_____ I do not authorize the following information to be disclosed to any of the parties listed above (please specify):
_____

_____

I authorize my medication history to be obtained by my physician and his staff.

This authorization is effective unless revoked or terminated in writing by the patient or the patient's authorized representative.

I have reviewed the "Notice of Privacy Practices."

_____ _____
Signature of Patient Date

_____ _____
Patient Representative - Print/Sign Date

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient Name: _____ DOB: _____

Pt Address: _____

_____

Ph #: _____

Entity Authorized to Release Medical Records: _____

_____

Ph: _____

This authorization will expire on the following date or event indicated or 12 months from the date signed.

Event: _____ Date: _____

Purpose of Disclosure: _____

Records: Start Date: _____ End Date: _____

_____ History, Progress/Visit Notes
_____ Labs
_____ EKGs, Stress Tests, Diagnostic Tests
_____ Radiology
_____ Operative Reports & Diagrams
_____ Other: _____

The following will be release unless checked below:

_____ AIDS/HIV results
_____ Alcohol/Drug/Substance Abuse Treatment
_____ Psychiatric/Mental Care
_____ Other _____

I understand that:

1. I may refuse to sign this authorization, and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but it will not have any effect on actions taken prior to the receipt of the revocation.
4. If the requester or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after signed.

Patient Signature: _____ Date: _____

Patient Legal Rep (proof required): Relationship: _____

_____ Date: _____