# Patient Registration Form

Patient's Legal Name: (Last) _____(First) _____ (MI) _____

Date of Birth: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone Number: _____

SSN: _____

Marital Status: Single ____ Married ____ Divorced/Separated ____ Widowed ____

Gender: Male _____ Female ____

Primary Care Provider: _____

Preferred Pharmacy: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

**INSURANCE INFORMATION**

Primary Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Name of Insured (if not patient): _____

Relationship: _____ Date of Birth: _____

Secondary Insurance Carrier: _____

Policy Number: _____ Group Number: _____

___ I HAVE NO HEALTH INSURANCE

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**OUR LEGAL DUTY**

We are required by federal and state law to:

- Maintain the privacy and security of your protected health information (PHI).
- Provide you with this Notice of Privacy Practices.
- Follow the terms of the notice currently in effect.
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

We reserve the right to change this notice at any time. Any revised notice will apply to all records we maintain and will be available in our office and upon request.

**HOW WE MAY USE AND DISCLOSE YOUR INFORMATION**

1. Treatment

We may use and share your information with physicians, hospitals, laboratories, pharmacies, and other healthcare providers involved in your care.

2. Payment

We may disclose information to insurance companies, Medicare, Medicaid, or other third-party payers to obtain payment for services provided.

3. Healthcare Operations

We may use your information for quality assessment, credentialing, medical review, training, auditing, business management, and administrative activities.

4. As Required by Law

We may disclose information when required by federal, state, or local law, including public health reporting, abuse reporting, health oversight activities, law enforcement requests, court orders, and national security requirements.

5. Business Associates

We may share your information with contracted service providers (business associates) who perform services on our behalf. These entities are legally required to safeguard your information.

6. Appointment Reminders & Communication

We may contact you by phone, voicemail, text message, email, or mail regarding appointments, treatment, billing, or healthcare operations unless you request otherwise in writing.

7. Individuals Involved in Your Care

Unless you object, we may disclose relevant information to a family member, caregiver, or person responsible for your care.

**USES REQUIRING YOUR WRITTEN AUTHORIZATION**

We will obtain your written authorization before:

- Using or disclosing psychotherapy notes (if applicable).
- Using your information for marketing not permitted by law.

You may revoke an authorization in writing at any time. Revocation will not apply to actions already taken.

**YOUR RIGHTS**

You have the right to:

- Inspect and obtain a copy of your medical record (fees may apply).
- Request an amendment to your record.
- Request restrictions on certain disclosures (we are not required to agree to all requests).
- Request confidential communications.
- Receive an accounting of certain disclosures.
- Obtain a paper copy of this notice at any time.
- File a complaint without fear of retaliation.

To exercise these rights, you must submit a written request to our office.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. Filing a complaint will not affect your care.

**ACKNOWLEDGMENT OF RECEIPT**

I acknowledge that I have received or been offered a copy of this Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____

If signed by personal representative:
Name: _____ Relationship: _____

# CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

**Consent for Medical Evaluation and Treatment**

I voluntarily consent to medical evaluation and treatment by the physicians and clinical staff of Georgia Cardiology Associates.

This may include:

- Medical examination
- Diagnostic testing
- Review of medical records
- Coordination of care with other providers

I understand that separate consent will be obtained for any invasive procedures.

I may withdraw consent in writing at any time.

**Financial Responsibility**

I understand and agree that:

- My insurance will be billed as a courtesy.
- I am responsible for all charges not covered by insurance.
- Copays and deductibles are due at the time of service.
- Unpaid balances may be referred to collections.

**Appointment Policy**

- Please provide 24-hour notice for cancellations.
- Missed appointments may incur a $25 no-show fee.
- Patients arriving more than 15 minutes late may be rescheduled.

**Communication Preferences**

May we contact you regarding appointments or medical information?

□ Phone
□ Voicemail
□ Text message
□ Email
□ Patient portal

Preferred Contact: _____

I understand that electronic communications may carry limited privacy risk.

□ I consent to electronic communication.

Patient / Representative Name: _____ Date: _____

Signature: _____

# RELEASE OF MEDICAL INFORMATION

Our practice is committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information, or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail without your permission.
Under HIPAA regulations, we may provide this information to other healthcare entities involved in your care and insurance companies for billing purposes without your permission. A photocopy of this shall be considered as valid as the original.

Communication Preferences:

You may leave a detail message on my voicemail: YES NO
You may discuss medical information with the following individuals:

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Relationship of Guardian ( if applicable): _____

# General Cardiology Medical Intake

Name: _____ Date of Birth: _____

Reason for visit: _____

Cardiac Symptoms (check all that apply):

___ Chest pain ___ Shortness of breath ___ Palpitations ___ Swelling ___ Dizziness/ Fainting.

___ High Blood Pressure ___ Other: _____

Current Medications ( Name / Dose / Frequency)

_____

_____

_____

Are you allergic to any medications: Yes/No ( If YES, please list)

_____

Past Medical History:

___ Coronary artery disease ___ Heart Attack ___ Heart Failure ___ Atrial fibrillation

___ Hypertension ___ Diabetes ___ Stroke ___ Peripheral Vascular disease ___ Sleep Apnea

___ Thyroid disease ___ Asthma ___ Other: _____

Prior Surgeries/Procedures ( Procedures & Year)

_____

_____

Social History:

Tobacco: ___ Never ___ Former ( Quit: _____) ___ Current ( Packs/day: _____)

Alcohol: ___ None ___ Yes ( Drinks/ week; _____)

Illicit Drug use: ___ No ___ Yes

_____

# PATIENT INTERIM HISTORY

Patient Name: _____ DOB: _____ Date:_____

Since last doctor visit: ___ ER visit ___ Hospitalization ___ New diagnosis ___ New test ___ No changes.
Details: _____
_____

Medication Changes: ___ None ___ Yes

_____

Current Symptoms:
___ Chest Pain ___ Shortness of breath ___ Palpitations ___ Swelling ___ Dizziness
___ Leg Pain ___ Wound Issues ___ None

Home BP Average: _____ Home Glucose: _____

**Family History**

Please check if any blood relatives have had the following conditions.

| Condition | Father | Mother | Brother/Sister | Grandparent |
|---|---|---|---|---|
| High Blood Pressure | | | | |
| Diabetes | | | | |
| Heart Disease | | | | |
| Stroke | | | | |
| Cardiomyopathy | | | | |
| Aneurysm | | | | |
| Chronic Kidney Disease | | | | |

Other significant family medical problems:

_____

# PERIPHERAL ARTERIAL DISEASE (PAD) SCREENING

Peripheral Arterial Disease (PAD) occurs when arteries in the legs become narrowed or blocked. This can increase the risk of heart attack and stroke.
Please **CIRCLE** YES or NO.

| | | |
|---|---|---|
| Pain or cramping in legs when walking that improves with rest | **Yes** | **NO** |
| Pain in legs or feet while resting | **Yes** | **No** |
| Foot or toe pain that wakes you from sleep | **Yes** | **No** |
| Toes or feet that appear pale, blue, or discolored | **Yes** | **No** |
| Wounds on feet or toes that heal slowly | **Yes** | **No** |
| Doctor has told you your foot pulses are weak | **Yes** | **No** |
| Prior serious injury to legs or feet | **Yes** | **No** |
| Infection or gangrene in the leg or foot | **Yes** | **No** |

## PAD RISK FACTORS

Check all that apply:
□ Age over 70
□ Age 50–69 with smoking history or diabetes
□ Age under 50 with diabetes and another risk factor
□ Smoking history
□ High cholesterol
□ High blood pressure

## PRIOR VASCULAR TESTING

Have you ever had an Ankle-Brachial Index (ABI) circulation test?
□ Yes
□ No
If yes, where was it performed? _____

Patient Signature: _____
Date: _____