



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