CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

PATIENT REGISTRATION

CFCG Physician _____ Date: _____

First Name: _____ Middle: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Phone / Contact: _____

Sex: F / M Marital Status: _____ DOB: _____ Social Security: _____

Referring Physician: _____

How did you hear about us? _____

Employer Name: _____

Address: _____

Phone #: _____

Insurance Information

Pre-certification telephone #: _____

Primary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____Subscriber's Social Security_____

Subscriber's Employer Name: _____

Secondary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____Subscriber's Social Security_____

Subscriber's Employer Name: _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as an original. I authorize said assignee to release all information necessary to secure payment. I understand I am responsible for any deductible, co-payment, and or non-covered services. In the event my account is assigned to collection, I agree to pay all cost of collection including reasonable attorney fees.

_____ _____

PATIENT'S SIGNATURE DATE

SEE BACK

CFCG-7 3/2011
Metrovista: Corporate Printing Solutions
Reorder at www.metrovista.com or call 1-866-725-5100

CONSENT FOR TREATMENT

I herby consent to the physicians and/or other certified practicing clinicians of Central Florida Cardiology Group, to provide clinical evaluation and treatment services. In the event of an emergency I consent to receive whatever treatment is deemed necessary.

Patient Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

I understand I am responsible for the payment of services rendered to me. I authorize Central Florida Cardiology Group to furnish information to other physicians involved in my care and to my insurance carrier(s) concerning my medical history, illness and treatment. I herby assign all medical benefits rendered to me to which I am entitled.

Patient Signature: _____

Date: _____

LIFETIME AUTHORIZATION ASSIGNMENT FOR MEDICARE BENEFICIARY

I request payment of authorized medicare benefits to be made on my behalf for any services furnished by a physician of Central Florida Cardiology Group, P.A.

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____

Date: _____