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Cardiac and Vascular Diseases
Interventional and Nuclear Cardiology
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PATIENT INFORMATION REGISTRATION FORM

Please print clearly (Imprima claramente)
Name (Nombre): _____Age (Edad):_____ Sex (Sexo): ____
Date of Birth (Fecha de nacimiento): _____S.S. # (# de Seguro Social): _____
Address (Dirección): _____City (Cuidad):_____
State (Estado): _____Zip (Código postal): _____
EMAIL ADDRESS (CORREO ELECTRONICO)_____
Married (Casado):_____Single (Soltero): _____Divorced (Divorciado):_____Widow (Viudo): _____
Home Phone (Teléfono de casa): _____
Cell Phone (Teléfono celular): _____

Employer Name (Nombre del empleador): _____Phone# (# de teléfono):_____
Address (Dirección): _____ Occupation (Ocupación): _____
City (Cuidad): _____State (Estado): _____Zip (Código postal): _____

Spouse (Cónyuge): _____Phone # (# de teléfono) _____
Date of Birth (Fecha de Nacimiento):_____

NAME OF YOUR PRIMARY CARE PHYSICIAN(CUAL ES EL NOMBRE DE SU MEDICO PRIMARIO)

Physicians name: _____Phone # (# de teléfono)_____
INSURANCE INFORMATION (INFORMACION DE SEGURO)
Primary Carrier (Seguro principal): _____
Secondary Carrier (Seguro secundario): _____
Tertiary insurance_(Seguro _Tercer)_____
Please Circle Race (Por favor Círcule Compite): Black ** White * *Hispanic ** Other _____
Please Circle Preferred Language (Por favor Círcule el Prefirió Idioma): English * *Spanish**Other
_____
Please Circle Ethnicity (Por favor rodee Etnia): White American ** Hispanic/Latino * *African American **
Asian American * American Indian* * Mixed **Other_____

***** CO-PAYS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED*****

***** LOS COPAGOS Y DEDUCIBLES SERAN PREVISTO AL TIEMPO DEL SERVICIO*****

TREATMENT AUTHORIZATION:
I hereby authorize North Lake Cardiovascular Center to undertake medical treatment, diagnostic testing, as deemed medically necessary.

PAYMENT AUTHORIZATION:

I, _____hereby authorize Ahmed Hashim M.D. to furnish information concerning services rendered. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. A photostatic copy of this authorization will be as valid as the original.

Obtaining referral information is the patient's responsibility.

In the event my account should become delinquent, I will be responsible for all collection fees.
These fees will include a 15% service charge and any legal fees incurred through the collection process.

All payments due because of patient's failure to cancel appointment will be billed direct to the patient for payment. Reimbursement from Insurance will be patient's responsibility.

_____ _____
SIGNATURE (FIRMA) **DATE (FECHA)**

SELF PAY PATIENTS:

NORTH LAKE CARDIOVASCULAR CENTER is happy to serve patients that do not have insurance and/or patients that are self-pay. It should be noted that payment is required for the services listed below on the day that the service is rendered.

Procedure	**REQUIRED At TIME OF VISIT**
Office Visit – Established Patient	$ 115.00
Office Visit – New Patient	$ 165.00
Echocardiogram	$ 250.00
Vascular Ultrasound	$ 265.00
ABI Ankle Brachial Index	$ 100.00
Nuclear Stress Test –	$ 800.00
Pharmacological Stress test	$ 1000.00
Stress Test – Treadmill only	$ 180.00
Holter Monitor	$ 100.00

I understand that as a self-pay patient, I am responsible for the above listed amounts for the services provided by NORTH LAKE CARDIOVASCULAR CENTER on the day the services are delivered.

_____ _____
SIGNATURE (FIRMA) **DATE (FECHA)**