



Champion Heart & Vascular Center, PA
710 Erwin Rd, Dunn, NC 28334
P: 910.304.1212 F: 910-292-2627

New Patient Registration Forms
(Please Print Clearly)

Patient Information

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____ SSN: _____ Male: _____ Female: _____

Marital Status: **(Circle One)** Married Single Divorced Widow Separated Domestic Partner

Phone Number: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Insurance:

Primary Insurance: _____

Member ID/Number: _____ Subscriber: _____

Secondary Insurance: _____

Member ID/Number: _____ Subscriber: _____

Other:

Primary Care Physician: _____

Practice/Location: _____

Preferred Pharmacy: _____

Phone/Location: _____

Patient History:

Medical Diagnosis: _____

Current Medication: _____

Allergies: _____



AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____

First Name

MI

Last Name

Date of Birth: _____ Soc. Sec. # _____

Authorized Individual(s)

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

This request and authorization apply to:

- ☐ All Healthcare Information.
- ☐ Healthcare Information relating to the following treatment, conditions, or dates: _____
- _____
- _____

Definition: I understand that authorizing the disclosure of health information is voluntary. I can revoke this authorization at any time. To revoke, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the information in my health records may include information relating to STD, AIDS, or HIV. It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature

Date



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

First Name

MI

Last Name

Date of Birth: _____

Soc. Sec. # _____

Physician Office Information

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Fax: _____

This request and authorization apply to:

☐ All Healthcare Information.

☐ Healthcare Information relating to the following treatment, conditions, or dates: _____

☐ Yes ☐ No I authorized the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorized the release of my records regarding drug, alcohol, or mental treatment to the person(s) listed above.

Patient Signature

Date



Patient Financial Responsibility Acknowledgement Form

Copays, co-insurance, and deductibles are due at the time of services. If you have medical insurance to cover your expenses, as a courtesy to you, we will file to your insurance. We want to help you receive your maximum allowable benefits, and in order to achieve these goals, we will need your assistance and understanding of our payment policy.

When you agreed to your insurance policy you agreed to pay all and any copays, co-insurances and deductibles at time services are rendered to you.

If you do not have medical insurance, you are expected to pay for the services that are rendered to you at time of service, we offer a self-pay discounted rate to help you as a courtesy. We realize that individual financial situations may affect timely payments, and in this case we can offer a payment plan for services rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to contact to ask our staff. We are here to help.

This is to certify that I, the undersigned, agree to accept full responsibility for the payment of all fees and that I have read, understand, and agree to the financial arrangements stated above.

Patient/Responsible Party Signature

Date



Payment Policy

Thank you for choosing us for your Vascular, Veins and Cardiology services. We are committed to providing you with quality and affordable health care. Please read the following regarding patient and insurance responsibility for services rendered. After you read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most of the insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits, network status of the company and non-covered services is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment, co-insurances, and deductibles at each visit.

3. Proof of insurance. All patients must complete our patient information form before seeing the doctor or provider. Please come prepared with a copy of your driver's license and current valid medical insurance to provide proof of insurance and your up to date address at every visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party of that contract.



5. Coverage changes. If your insurance coverage has changed or been updated since your last visit please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. Failure to submit these changes will result in your responsible for the balance.

6. Nonpayment. Our office mails out patient statements every month. If your account is over 90 days past due, and you have not contacted our office to set up a payment plan agreement. Your account will be turned over to our collections agency. This may result in being discharged from the practice due to nonpayment of balance . You will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. Missed/Cancel appointments. Our policy is to charge \$50 for cancelled or no show appointments. Appointment must be cancelled 24 hours in advance prior to schedule appt time. Same day cancellation will result in a \$25 charge.

8. Procedure Cancel appointments. No show or same day cancellation will result in a \$75 charge for procedures. Nuclear Stress Test no show or same day cancellation will result in a \$250 charge.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date



Patient Cancellations Policy

Policy:

It is the policy of the practice to monitor and manage appointment no shows, late, and cancellations. Champion Heart and Vascular Center's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours prior to their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedures:

No show or same day cancellation will result in a \$75 charge for Procedures "RF Ablations, Iliac Venogram, Peripheral Angiogram", and \$250 for NST (Nuclear Stress Test).

Established Patients:

- Appointments must be cancelled 24 hours in advance prior to the scheduled appointment time. Same day cancellation will result in a \$25 charge.
- In the event of a patient arrives late as defined by "late arrival" 15 minutes allowed time and cannot be seen by provider on the same day, they will be rescheduled for a future office visit, if available. In the event a patient incurred three (3) documented "no shows" and / or "same day cancellations", the patient may be subject to be dismissed from Champion Heart and Vascular Center.

New Patients:

- Appointment must be canceled at least 24 hours prior to scheduled appointment time. Will be charged a \$50 No Show or Cancellation Fee.
- In the event of a no show, Referring Physician will be notified and we will attempt to reschedule the patient. If New Patient no shows Three (3) documented appointments they will need to be referred to another cardiologist.

I have read and understand Champion Heart and Vascular patient cancellation policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

Patient Signature

Date



Patient Name: _____

Procedure(s): _____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by North Carolina Law, and not by a lawsuit or resort to court process except as North Carolina Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2: I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatments or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to a claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

5: I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

Date

If signed by other than patient, indicate relationship:

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 4 above.

(Physician or Duly-Authorized Representative)

Date



Acknowledge of Receipt of Notice of Privacy Rights

We Are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

I acknowledge that I have received a copy of this office Notice of Privacy Practices

Print Name

Signature

Date



Video Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Champion Heart & Vascular Center, its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

- (a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;
- (b) Permission to use my name; and
- (c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and does not require prior approval by me.

Printed Name

Signature

Date

If the individual photographed/recorded is under eighteen (18) years old, the following section must be completed: I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am the parent or guardian of the child named above.

Printed Name of Parent/Guardian of Individual Photographed/Recorded

Signature of Parent/Guardian

Date