

**Pacific Heart Associates, P.C.**  
**Patient Registration**

Today's Date \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Name \_\_\_\_\_

Marital Status: <sup>First</sup> Minor      Single      <sup>Middle</sup> Married      Widowed      <sup>Last</sup> Divorced

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex    M    F

Address: \_\_\_\_\_

Primary Phone \_\_\_\_\_ <sup>Street</sup> Home or Cell    Secondary Phone \_\_\_\_\_ <sup>City</sup> <sup>State</sup> <sup>Zip</sup> Home or Cell

Email Address \_\_\_\_\_

Employment Status:    Employed      Unemployed      Retired      Disabled

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (other than spouse)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

ID/Policy Number \_\_\_\_\_ ID/Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Group Number \_\_\_\_\_

Claims Address \_\_\_\_\_ Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_      City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

What is your preferred method of contact for test results?

Email \_\_\_\_\_

Fax \_\_\_\_\_

Mail to Home Address or Mail to Other Address: \_\_\_\_\_

In the event that PHA is not able to reach you, we would like permission to leave detailed messages for you. This could include, but is not limited to test results, appointment confirmations or prescription refills.

Yes, I give my permission for PHA to leave detailed messages at the phone number(s) I have listed below.

Number(s) approved for detailed messages \_\_\_\_\_

No, do not leave detailed messages for me.

The following information will be used to ensure that all patients receive the best care possible. The information provided will remain confidential. Please circle.

Primary Language:            English                            Spanish                            Other: \_\_\_\_\_

Race:            Black, African American  
                  White, Caucasian  
                  Asian  
                  American Indian, Alaska Native  
                  Native Hawaiian, Other Pacific Islander  
                  Unknown  
                  Declined

Ethnicity:        Hispanic or Latino  
                  Non-Hispanic or Non-Latino  
                  Declined  
                  Unknown  
                  Blank

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

-OR-

Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Pacific Heart Associates, P.C.**  
**Release of Information and Assignment**  
**And Financial Policy**

**Release of Information and Assignment**

I authorize Pacific Heart Associates, P.C. to furnish my insurance company any information necessary to process my insurance claims. I hereby assign to Pacific Heart Associates, P.C. all insurance payments relative to the services performed. I understand that I am responsible for any amount not covered by my insurance. If for any reason this account is assigned to an outside collection agency I will be responsible for any collection cost, such as attorney's fees and/or court costs. I understand and agree to the financial policy established by Pacific Heart Associates, P.C. as stated above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Policy**

Pacific Heart Associates, P.C. (PHA) is a member of many insurance plans. Complete insurance information must be provided to PHA at the time of service in order for us to bill your insurance directly. The patient will be responsible for the balance if this information is not provided. Please contact your insurance or the billing department if you are unsure whether PHA is a contracted provider.

**Medicare Claims:** PHA is currently a participating provider in the Medicare program. Our office will forward all charges to Medicare. The patient will be responsible for payment of their yearly deductible and 20% of the amount "approved" by Medicare.

**Non-Medicare Claims:** Co-pays are due at the time services are rendered. If your co-pay is not paid at your visit, a \$25.00 billing fee will be assessed to your account. After your insurance has been billed, any deductible or co-insurance due should be paid within 30 days of notification from PHA or your insurance carrier, unless a payment plan has been established with the billing department.

**Secondary Claims:** PHA will bill your secondary carrier as a courtesy. Any balance due after the primary and secondary payment is expected within 30 days of notification from PHA or your insurance carrier. We do not bill tertiary insurance companies, with exception to Oregon Health Plan.

**Uninsured Patients:** All patients who are uninsured are asked to pay in full at the time of service. Arrangements must be made with the billing staff prior to being seen if you are unable to make payment in full.

**Returned Check Fees:** All returned checks will be subject to a \$35.00 fee.

**Nuclear Imaging Drug Fees:** There will be a fee of \$50.00 to \$150.00 for unusable drug costs for nuclear studies not cancelled 24 hours prior to the appointment time.

A copy of this financial Policy is available upon request.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Patient Name \_\_\_\_\_ Account # \_\_\_\_\_