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## PATIENT INFORMATION REGISTRATION FORM

(Please print clearly)

Patient's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Married  Single  Divorced  Separated  Widowed

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

In case of emergency contact (other than spouse): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

### REFERRAL INFORMATION: (Please tell us how you were referred to our practice)

Physician/Other: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Coverage, Name of Carrier: \_\_\_\_\_  
Secondary Coverage, Name of Carrier: \_\_\_\_\_

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

Are you covered by Medicare?  Yes  No Medicare No: \_\_\_\_\_  
Railroad? \_\_\_\_\_

**TREATMENT AUTHORIZATION:**

I hereby authorize Delta Convenient Care, P.C. and its associates to undertake medical treatment, diagnostic testing as deemed medically necessary.

**PAYMENT AUTHORIZATION:**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_, 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. Although covered by insurance, I am aware that I am personally responsible for all charges. 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 (PATIENT OR PARENT IF UNDER 18 YEARS OF AGE)**

\_\_\_\_\_  
**DATE**

**SELF PAY PATIENTS:**

Delta Convenient Care, PC is happy to serve patients that do not have insurance and/or patients that are self-pay. It should be noted that deposits are required for the services listed below on the day that the service is rendered.

<u>Procedure</u>	<u>Deposit Required</u>
Office Visit – Established Patient	\$50.00
Office Visit – New Patient	\$100.00
Echocardiogram	\$200.00
Vascular Ultrasound	\$200.00
CT/CTA Scan	\$400.00
Stress Test – with Nuclear Medicine	\$400.00
Stress Test – Treadmill only	\$100.00
Renal Ultrasound	\$50.00
Holter Monitor	\$75.00
Heart Catheter	\$250.00

I understand that as a self-pay patient, I am responsible for the above listed deposit amounts for services provided by Delta Convenient Care, PC on the day the services are delivered. I will be billed for the remaining amount of the cost of the service.

\_\_\_\_\_  
**SIGNATURE (PATIENT OR PARENT IF UNDER 18 YEARS OF AGE)**

\_\_\_\_\_  
**DATE**