207 Chartwell Court • Myrtle Beach, South Carolina 29588 • (843) 293-2700

NEW PATIENT DEMOGRAPHICS

PATIENT INFORMATION

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **SS#:** _____-____-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Mobile:** _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Domestic Partner

Primary Care Physician: _____

My Pharmacy: _____ **Phone:** _____

I authorize South Strand Cardiology to leave test results or messages on my answering machine: ❑ Yes ❑ No

EMPLOYMENT INFORMATION

❑ Employed ❑ Self Employed ❑ Unemployed ❑ Disabled ❑ Retired

Occupation: _____

Employer's Address: _____

Employer's Phone: _____

Who may we thank for referring you to our office? _____

In case of an emergency who should be notified? _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **Membership #:** _____

Policy Holder's Name: _____ **Date of Birth:** _____ **SS#:** _____-____-_____

Secondary Insurance Name: _____ **Membership #:** _____

Policy Holder's Name: _____ **Date of Birth:** _____ **SS#:** _____-____-_____

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ASSIGNMENT AND RELEASE

I, _____, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance companies listed above and assign directly to South Strand Cardiology, LLC/Erol Lale, all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor release all Information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ **Date:** _____
(Responsible Party Signature)

Acknowledgement of Receipt of Privacy Practices

I, _____, have received the Notice of Privacy Practices from South Strand Cardiology, LLC.

_____ **Date:** _____
(Patient Signature)

Authorization to Release Information

I, _____, hereby authorize South Strand Cardiology, LLC to release the following information:

Appointment Notices, Prescription and Sample Pick-up, Lab Results, Inquires on Insurance Information, and Notices of Collections to the specified individuals listed below.

Before South Strand Cardiology, LLC will release any private health information, the following individuals will have to verify relationship and knowledge of patient.

Name of Individual:	**Relationship to Patient:**	**Phone:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

South Strand Cardiology, LLC may leave me a message (please check all that applies):

❏ Home ❏ Cell Phone ❏ Work Phone ❏ email: _____

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I hereby authorize the attending and consulting physician to release information concerning my treatment to any insurance company requesting the same for the purposes of determining eligibility for payment of insurance benefits. AND I hereby authorize payment to any and all physicians involved in my treatment or diagnosis of my benefits specified and otherwise payable to me, but not exceed the reasonable and customary, charges. I understand that I am financially responsible to these physicians for charges not covered by this assignment.

You have the right to request any specific changes deviating from above procedure and how you would like us to restrict your protected health information in disclosing to any individuals or institution.

If you would like us to make specific restrictions, please ask one of the staff to assist you with your request. For this, you may need to fill out an additional form that specifies the requested restrictions (Form to Request Restrictions on Use and Disclosure of Protected Health Information).

_____ **Date:** _____
(Patient Signature)

To all of our valued patients: In order to continue providing you with our services, all payments must be paid for at the time of your visit, prior to the services rendered. Our office staff will assist you with obtaining the necessary pre-certification for all tests prior to being performed. Your payment of co-pay, deductible and any additional percentage that is required by your insurance company is due at the time of your visit, prior to the services rendered. By allowing us to provide you with cardiac care services, you also acknowledge and accept your responsibility for payment of all other charges that are not covered by your insurance policy.

Name: _____

_____ **Date:** _____
(Patient Signature)

Witnessing Staff Member: _____ **Date:** _____

Please Note: If you are currently going through a financial hardship, please notify us of your circumstances at the time of your visit. We will listen to you and try to help you arrange an alternative to meet your financial responsibility.