



100 Innwood Drive
Covington, LA 70433
phone: (985) 273-3035 fax: (985) 273-3036

PATIENT REGISTRATION FORM

Patient Information (please print)

DATE: _____

NAME: _____ DOB: _____

SOCIAL SECURITY #: _____

SEX: M _____ F _____

MARITAL STATUS: S M D W

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ TELEPHONE (CELL): _____

TELEPHONE (WORK): _____ EMAIL: _____

EMERGENCY CONTACT:

NAME: _____ TELEPHONE: _____

PRIMARY CARE PHYSICIAN: _____

SIGNATURE: _____ DATE: _____



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PAYMENT POLICY

Patient Responsibility

You are responsible for all charges resulting from treatment provided by Cardiovascular Clinic of Covington, LLC. We bill most insurance carriers; however, primary responsibility for the account is yours. Your co-payment is always due at the time of service. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

Insurance Billings:

It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.

I hereby certify that I (or my dependent) have the insurance coverage that I (or my dependent) presented and assign all benefits directly to Cardiovascular Clinic of Covington, if any, otherwise payable to the services rendered.

Check Returned:

It is our office policy to charge a \$25.00 fee for checks that are returned.

Authorization to Release Information:

In obtaining payment for services, I authorize my healthcare provider, Cardiovascular Clinic of Covington/Dale A. Presser, MD. to release all information necessary from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance company(s) or their representatives and my employer or union if they are involved in processing the claim. I authorize the use of this signature for all insurance submissions.

If I have been referred by, or am being referred to another healthcare provider, I authorize Cardiovascular Clinic of Covington to release my medical information to this provider for continuing care.

I also assign Cardiovascular Clinic of Covington all payments to which I am entitled for medical expenses related to the services reported herewith.

HIPAA:

I acknowledge that I have received a copy of Cardiovascular Clinic of Covington's Notice of Privacy Practices.

Consent:

I hereby authorize Cardiovascular Clinic of Covington's physicians and staff to administer or perform medical treatment including procedures or services as they deem necessary or reasonable, including chest x-ray, laboratory services and diagnostic procedures.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Patient Name (please print) Patient's Signature Date
If Patient is under 18 years of age or is Otherwise Unable to Sign, Complete the Following:]
Patient is _____ year(s) of age or is unable to sign because: _____

Signature Relationship to Patient Date



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Assignment of Benefits and Release of Information Authorization:

1. I certify that I (or my dependent) have the insurance coverage that I presented and assign all benefits directly to Cardiovascular Clinic of Covington/Dale A. Presser, MD, if any, otherwise payable to the services rendered.
2. I understand that I am financially responsible for all charges whether or not paid for by my insurance company.
3. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.
4. I acknowledge that I have received a copy of Cardiovascular Clinic of Covington's Notice of Privacy Practices.
5. I hereby authorize Cardiovascular Clinic of Covington/Dale A. Presser, MD's staff to administer or perform medical treatment including procedures or services as they deem necessary or reasonable, including chest x-ray, laboratory services and diagnostic procedures.

Signature

Date

Printed Name

Description of relationship if not patient



Cardiovascular Clinic of Covington, LLC
100 Innwood Dr Covington, LA 70433

24 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Cardiovascular Clinic of Covington, LLC reserves the right to charge a fee of \$25.00 for each missed (No Show) appointment on the Ultrasound schedule, which is, absent for a compelling reason, and is not cancelled within a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy

Printed, Last Name, First

Date

Signature

CARDIOVASCULAR CLINIC OF COVINGTON
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PHONE: (985) 273-3035

FAX: (985) 273-3036

Patient Identification

Printed Name _____ Date of Birth: _____

Address: _____

Social Security # _____ Telephone No.: _____

Authority to Release Protected Health Information

I hereby authorize _____ to release information identified in this authorization from the medical records of _____ (Patient's Name) and provide such information to _____.

Information to be Released – Covering the Periods of Health Care from (date) _____ to _____

Complete Medical Record

Partial Medical Record specifically to include

<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Laboratory Test Results	<input type="checkbox"/> X-ray Films/Images	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Photographs & Videotapes	<input type="checkbox"/> Discharge Summary	_____
<input type="checkbox"/> Diagnosis & Treatment Codes	<input type="checkbox"/> Progress Notes	_____
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Complete Billing Record	_____

Purpose of the Requested Disclosure of Protected Health Information – I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”): At patient’s request.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release – I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and /or other sensitive information, I agree to its release. **Check One: YES NO**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One: YES NO**

Expiration Date – Unless revoked, this authorization will expire on the following date, or after the following time period or event: 10 years.

Right to Revoke Authorization – Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice.

Re-disclosure – I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure – I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge Cardiovascular Clinic of Covington, its employees, agents and owners of any liability and the undersigned will hold them harmless for complying with this authorization.

Signature: _____ Date: _____

Description of Relationship (if not patient): _____



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Designation of Personal Representative

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization you are informing us of your designation of the named person as your Personal Representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

I, _____ hereby designate _____, to Act as my Personal Representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: _____

Representative's Date of Birth _____

Representative's Driver's License No. or _____

Other Picture ID No. _____

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: _____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to **CARDIOVASCULAR CLINIC OF COVINGTON, LLC**, 100 Innwood Drive, Covington, LA 70433. I further understand that such revocation does not apply to the extent that persons how have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

Signature

Date

Last four (4) digits of SS#

Date of Birth

REVOCATION

I hereby revoke this designation of a personal representative.

Signature

Date



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (print name) hereby acknowledge that I have received a copy of the Notice of Privacy Practices of **CARDIOVASCULAR CLINIC OF COVINGTON**.

Signature

Date

Printed Name

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient;
- Power of Attorney, Tutrix, Curator or Designated Personal Representative

Name of Patient

Acknowledgement refused:

Efforts to obtain:

Reason for refusal:



History and Physical Patient Form

Name:	Today's Date:	
Date of Birth:	Height:	Weight:
Primary Care Physician:		
Referring Physician:		
Reason for your visit:		

Medical History: (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Aortic Aneurysm
<input type="checkbox"/> Arrhythmia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Atrial Flutter
<input type="checkbox"/> Blood Clot
<input type="checkbox"/> COPD
<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiomyopathy
<input type="checkbox"/> Carotid Disease
<input type="checkbox"/> Congenital Heart Disease
<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Deep Vein Thrombosis
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> GERD / Reflux
<input type="checkbox"/> Gastrointestinal Disease
<input type="checkbox"/> Genitourinary Disease
<input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hematologic Disease
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Kidney Disease

<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Neurological Disorder
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Peripheral Arterial Disease
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Stroke
<input type="checkbox"/> TIA
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Valvular Abnormalities
<input type="checkbox"/> Valvular Heart Disease
<input type="checkbox"/> Warfarin Management
<input type="checkbox"/> Aortic Regurgitation
<input type="checkbox"/> Aortic Stenosis
<input type="checkbox"/> Mitral Regurgitation |
|--|--|



Surgeries:

Date	Reason	Hospital

Current Medications:

Medication	Dosage	Frequency

Do you have any drug or food allergies? Yes No

If yes, please list: _____

What is your preferred Pharmacy? (Please include location) _____

Personal Habits:

Do you currently smoke or use smokeless tobacco? Yes No

If yes, amount: _____ Number of years: _____

Have you ever smoked or used smokeless tobacco? Yes No



If yes, date quit: _____

Do you drink alcoholic beverages ? Yes No

If yes, amount per week? _____ Number of Years _____

Do you use illicit drugs? Yes No

If yes, amount per day: _____ Date last used: _____

Do you drink caffeinated beverages ? Yes No

If yes, amount per day: _____

Do you exercise? Yes No

If yes, how often? _____ How Long Per Session _____

Do you follow a Specific Diet? If so, what? _____

Are you blind or have difficulty seeing? ___Yes ___No

Are you deaf or do you have serious difficulty hearing? ___Yes ___No

Do you have difficulty concentrating, remembering or making Decisions? ___Yes ___No

Do you have difficulty walking or climbing stairs? ___Yes ___No

Do you have difficulty dressing or bathing? ___Yes ___No

Do you have difficulty doing errands alone? ___Yes ___No

Have you been to an area known to be high risk for COVID-19? ___Yes ___No

Have you been around anyone within the last 14 days with COVID-19? ___Yes ___No

What is your highest level of education? _____

How would you rate your current stress level? _____

Do you use your seat **belt** routinely? ___Yes ___No

Do you have smoke detectors and carbon monoxide detectors at home? ___Yes ___No

Are there guns present at your home? ___Yes ___No

Do you use sunscreen routinely? ___Yes ___No

Do you have an advanced directives? ___Yes ___No



Family Medical History:

Have any of your immediate family members had any of the following? If yes, please list the

1. Heart Disease	Yes	No	
2. Stroke	Yes	No	
3. Afib	Yes	No	
4. Hypertension	Yes	No	
5. Blood Clot	Yes	No	
6. Myocardial Infarct (Heart Attack)	Yes	No	
7. CHF	Yes	No	
8. Valvular Heart Disease	Yes	No	
9. Cancer	Yes	No	

Signature: _____

Date: _____