CARDIOLOGY CONSULTANTS OF ATLANTA PC
2801 NORTH DECATUR RD, SUITE 395
DECATUR, GA 30033
(404) 298-2220 PHONE (678)904-5336 FAX

PATIENT REGISTRATION PLEASE PRINT

PATIENT INFORMATION								TODAY'S DATE
LAST NAME	FIRST	MI	ADDRESS				APT #	PO BOX
CITY	STATE	ZIP CODE	SEX	AGE	HOME PHONE	CELL OR PAGER	WORK PHONE	
DATE OF BIRTH	EMPLOYER/SCHOOL	MARITAL STATUS				RACE		
		SINGLE DIVORCED	MARRIED WIDOWED	AFRICAN AMERICAN	WHITE HISPANIC	MIDDLE EASTERN	Other	
EMPLOYED	EMPLOYER ADDRESS	SOCIAL SECURITY#	DRIVERS LICENSE#					

RESPONSIBILITY PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT PAID BY MY INSURANCE COMPANY ARE MY RESPONSIBILITY

LAST NAME	FIRST NAME	MI		
ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE	WORK PHONE	CELL OR PAGER	RELATIONSHIP	

PRIMARY CARE PHYSICIAN OR GROUP NAME

LAST NAME	FIRST NAME	ADDRESS	TELEPHONE

REFERRING DOCTOR PARTY OR GROUP NAME

LAST NAME	FIRST NAME	ADDRESS	TELEPHONE

DO YOU HAVE YOUR REFERRAL # FOR TODAY'S 'VISIT Y/N		WHICH HOSPITAL DO YOU USUALLY GO TO					
YES	NO	DMC	ROCKDALE	EMORY	PIEDMONT	GRADY	OTHER

IN CASE OF AN EMERGENCY CALL

NAME	WORK PHONE	HOME PHONE	CELL OR PAGER

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE

SUBSCRIBER (IF OTHER THAN PATIENT)	SEX	DATE OF BIRTH

SOCIAL SECURITY #	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY INFORMATION				
SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER			GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	TELE PHONE
SUBSCRIBER (IF OTHER THAN PATIENT)	SEX	DATE OF BIRTH		
SOCIAL SECURITY NUMBER	TELE PHONE			RELATIONSHIP TO PATIENT

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS AND CONSENT TO TREATMENT

- **I hereby authorize treatment by Cardiology Consultants of Atlanta, PC and the release of any information including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims or any medical information that is required for any health care related utilization review and/or quality assurance activities and/or attorneys, upon authorized HIPAA compliant request form.**
- **I hereby assign and authorize payment to Cardiology Consultants of Atlanta, PC of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy, or policies under any self-insurance program or under any other benefit plan.**
- **I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of these fees and charges not directly reimbursed to Cardiology Consultants of Atlanta, PC, by any insurance policy, self insurance program or other benefit plan.**
- **The authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as affective and valid as the original, I understand that I have the right to receive a copy of this authorization.**

<u>Medicare Beneficiary Agreement</u>

I request that payment of Medicare benefits be paid to Cardiology Consultants of Atlanta, PC for services rendered. I understand that I will be notified by Cardiology Consultants of Atlanta, PC if Medicare is likely to deny payment for services and I will be responsible for payment.

By signing below I authorize Cardiology Consultants of Atlanta, PC physicians and staff to administer medical treatment.

Patient's Signature **Date**

If the patient is unable to sign, please provide authorized signature of guardian or caretaker and their relationship to patient

---

Guardian/Caretaker **Relation to patient** **Date**