JAMES RIVER CARDIOLOGY

Patient Name: ______________________________ **Date:** ________________

Date Of Birth: ________________

Social Security Number: _________________________

Email Address: ________________________________

Address:

____

Home Phone: _____________________ **Cell Phone:** __________________

Referring Physician/Primary Care:____________________________________

Pharmacy:

____

Pharmacy Phone:________________________**Address:**__________________________

Race (circle): African American   Caucasian   American Indian   Asian   Hispanic   Other

Marital Status: Single ____   Married ____   Divorced____   Widowed ____

Preferred Contact: Cell Phone ____   Home Phone ____

Do you consent to receive email and/or text communication from James River Cardiology:

Yes_____   **No**_____

Please list two family members/friends that can be reached in case of an Emergency.

Emergency Contact:_____________________________ Relationship:___________

Phone Number___________________

Emergency Contact:_____________________________ Relationship:___________

Phone Number___________________

JAMES RIVER
CARDIOLOGY

Notice of Privacy Practices

We use information that you provide us, including health information, to carry out treatment, payment, and healthcare options. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionist or by calling the office at 804-520-1764.

You have the right to request that we restrict the use of your health information to carry out treatment, payment, or healthcare operations. We are not required to agree to the restrictions. If we do not agree to any restrictions, the agreement is binding.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions taken in reliance on the consent prior to the time you revoke it.

I understand and have been provided a copy of a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment, and healthcare operation purposes.

I give James River Cardiology, LLC the permission to discuss my medical information with the following:

Name:___________________________________**Phone:**______________________________

Relationship: _________________________________

Emergency contact: YES _____ NO ____

Name:___________________________________**Phone:**______________________________

Relationship: _________________________________

Emergency contact: YES _____ NO ____

Patient/Guarantor Signature: ____________________________________ **Date:** _____________

JAMES RIVER
CARDIOLOGY

Financial Agreement and Authorization

Basic Financial Policy: Payment is due and payable at the time of service.

Co-pays and Deductibles: All co-pays and deductibles required by your insurance company contract are due at the time of service. If you do not have your payment on the date of service, you will have 30 calendar days to submit payment. If payment is not received within the 30-days, your account will be charged an additional $15.

Commercial Insurance: You are responsible to know your insurance benefits, including what is not covered. We will bill the insurance with whom we have a current contract. You must provide us with current information within seven (7) business days of registration.

Private Pay Patient: If you do not have your insurance information with you when you register as a new patient, you will be considered a "private pay patient" and will be financially responsible for all services provided. Once your insurance information is provided, your insurance company will be billed; however, you will be financially responsible for all services your insurance company elects not to pay. If you do not have insurance, you will also be considered a "private pay patient" and will be financially responsible for all services. Payment in full is required for all "private pay patients" at the time of service. We offer private pay discounts as well as payment arrangements when needed.

Non-Covered Services: Any care not paid for by your existing insurance policy will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

Returned Checks: In addition to the face value of the check(s), you will be charged the fee we incurred from our banking institution as well as a $35 processing fee.

Collections: If any outstanding balance you owe James River Cardiology is referred to a collection agency or attorney, you agree to pay, in addition to all other amounts you owe, any and all costs of collection, including an attorneys fee equal to thirty-three and one third (33 ⅓ %) of my outstanding balance and other costs associated with collection. *You further agree to pay any related transaction fees, such as, but not limited to, credit/debit card fees, should you choose to pay your debt electronically*. If any indebtedness is not paid in full within sixty (60) days from the date of service, you agree to pay interest at a rate of 1.5% per month [18% per annum].

Forms/Copies: There will be a charge of $30 for completion of medical forms and paper copies of medical records. Payment is due when you make the request. Please allow fourteen (14) business days for the completion of the form and the copying of medical records.

MEDICARE Patients: I request that payment of authorized Medicare benefits be made either to me or on my behalf to James River Cardiology for any services furnished. I authorize any holder of my medical information to release that information to the Centers for Medicare and Medicaid Services in order to determine these benefits or the benefits payable for those services. **MEDICARE PATIENTS INITIALS: _______**

Patient/Guarantor Signature: __________________________________ Date: _____________

Medical Records Release

Patient Name: ______________________________________ **Date of Birth:_________________________**

Please allow 7-14 business days for all records requests.

May we obtain your previous Medical Record? Yes______ No______

Please provide name, speciality and phone number of all Physicians:

1. Name ______________________________Speciality _________________Phone ____________________

2. Name ______________________________Speciality _________________Phone ____________________

3. Name _____________________________ Speciality _________________Phone ____________________

Would you like for your other providers to receive a copy of your visits or testing results performed at James River Cardiology? Yes______ No_______

Please provide name, speciality and phone number of all Physicians:

1. Name ______________________________Speciality _________________Phone ____________________

2. Name ______________________________Speciality _________________Phone ____________________

3. Name _____________________________ Speciality _________________Phone ____________________

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, by submitting a request in writing to our practice. A copy of this consent shall be included in my original records.

Patient/Guarantor Signature: ___________________________________ **Date: _____________**