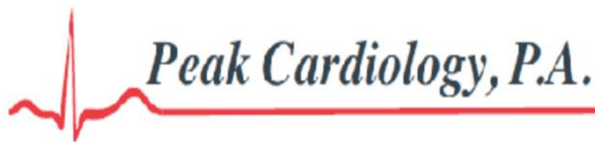

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1071 Pemberton Hill Road Ste 102
Apex, NC 2750

Phone: 919-363-6060
Fax: 919-363-6040

REGISTRATION

Patient Information: Date:_______________

Patient Name:____ Date of Birth:_________________

Sex: Male/Female Race:_______________________ Social Security Number:_________________

Address:____

City:___________________________ State:_____________________________ Zip_______

Home Phone:__________________ Cell phone:__________________ Best Contact: Home/Cell

Marital Status: Single/Married/Divorced/Widow Email:___________________________________

Occupation:_______________________________________ Employer:________________________

Emergency Contact

Name:_________________________ Relationship:_________________ Phone:_________________

Insurance Information:

Primary:

Insurance name:____________________ Policy Holder:_______________________ DOB:_________

Policy Number:______________________________ Group Number:___________________________

Insured relationship to Patient: Self Spouse Other:______________________

Address (if different then above):____

Secondary:

Insurance name:____________________ Policy Holder:_______________________ DOB:_________

Policy Number:______________________________ Group Number:___________________________

Insured relationship to Patient: Self Spouse Other:______________________

Address (if different then above):____

Consent

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize Peak Cardiology to release any PHI (Protected Health Information) to my insurance company that is required to process claims.

Signature:____ Date:__________________________

Peak Cardiology P.A.

MEDICAL HISTORY FORM

Please fill this form as much as possible – if need assistance nurse will assist you after check in.

Patient Name: ______________________________________ DOB: _________________Today's Date: _____________

Primary Care Provider/Physician:___________________________Practice:____________________________________

Preferred Pharmacy Name: _________________________Location/Address:___________________________________

Symptoms and Medical History

(Please write Y or N with approximate durations)

YOUR SYMPTOMS	YES	NO	Duration	YOUR MEDICAL HISTORY	YES	NO	Duration
Chest Pain or Discomfort				Diabetes /High Blood Sugar			
Shortness of Breath				High Blood Pressure			
Palpitations or Skipped Beats				High Cholesterol			
Fainting/ Blackouts/ Seizures				Prior Heart Attack			
Heart Rhythm Problems				Stroke or mini stroke (TIA)			
Heart Failure				Vascular Problems/ Blockages			
Coughing or Wheezing				Fever			
Heartburn or Acid Reflux				Hospitalized Due to Heart			
Heart Murmur				Kidney Problem			
Leg Swelling				Cancer or Tumors			
Internal Bleeding				Prostrate Problem			
History of heart, neck or leg stents?				Depression or Anxiety			
History of heart surgery?				Thyroid Problem			
History of carotid surgery?				Liver or Hepatitis			
History of leg vascular surgery?				Asthma/other lung problems			

Have you been seen by a cardiologist in the past? Yes/No If yes, when?__________________ Doctor?________________

Family history of Heart Disease? Yes/No If yes, Who?________________________ What?_________________________

Past Cardiac Complications:____

Have you Had a Treadmill Stress Test?: Yes/No Type (if known):___________________ Date (month/year):___________

Performing Doctor:______________________________ Location:____

Past Major Surgeries & Dates:____

Are you schedule for surgery? Yes/No Date:_________________ Type:__________________ Surgeon:________________

Do you smoke? Yes/No If yes, amount per day:____________ How long:____________ Quit? When:_______________

Do you drink? Yes/No If yes, amount per day:_____________ How long:____________ Quit? When:________________

Allergies to: Medications: Yes/No X-Ray/Dye Contrast: Yes/No Seafood/Shellfish/Iodine: Yes/No

If so, reactions:____

Post Menopausal: Yes/NO Last Menstrual Period:______________________ Number of Pregnancies:_______________

Are you on Hormone replacement? Yes/No If yes, how long?____

Medications

Name:	Dosage:	Frequency:

Peak Cardiology P.A.

Authorization of Release of Information and Communication

Patient Name:______________________________ **Date of Birth:**_______________

Peak Cardiology is authorized to release PHI (protected health information) in all manners listed below.
You must select a response in both boxes in order for us to release information. Failure to do so voids each section

Method/Entity to receive information:	**Information** approved to release (please check all information we are allowed to disclose):
Voicemail: __Cell __Home	**__Test results/Lab results** **__Medical information**
Email (provide email address below) ____________________________________ - Please accept disclosure below in order to receive email communication.	**__Financial** **__Medical** **__Appointment Reminders** **__Breach Notification**
Family (Provide name below) ______________________________________ ______________________________________ ______________________________________	**__Financial** **__Medical information**

Email/Text communication:
I understand and agree that if any information sent to me via email/text is not guaranteed to be encrypted and could be accessed inappropriately. I still would like to receive the above listed and approved communications via email or text.

Right to Revoke:
I am aware that I may revoke any of the above entities, methods, or information to release at any time as long as I do so in written format.

Signature: **Date:**

Patient Acknowledgement of Privacy Notice

Peak Cardiology is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. Peak Cardiology will not disclose your health information to anyone without proper notification from you the patient giving us the right to do so. **This information in detail is posted in the lobby area and is provided upon request at the time of registration.**
I acknowledge that I was informed of my HIPAA rights regarding my health information and may request a copy of this notice regarding the use and discloser of my health information.

Signature: **Date:**

Peak Cardiology P.A.

Financial Policy

1. The doctors and staff of Peak Cardiology are committed to providing you with the best possible medical care. We would also like to assist you in optimizing the benefits you obtain from your insurance carrier and in minimizing your concerns about the cost of the services you receive. In order to achieve these goals, your assistance is needed. As a service to our patients, we will bill your insurance company. If your insurance company requires a specific form, please bring or send the form to our office.
2. Insurance coverage is a contract between you and your insurance company. Peak Cardiology is not a party to that agreement. **ALL CHARGES ARE THE RESPONSIBILITY OF THE PATIENT.** If your insurance company does not pay our office within 60 days after filing, you will be responsible for paying the balance due with the exception of Medicare patients.
3. Prior to our office visit or cardiac testing we will be glad to assist you with the detailed information and codes we will most likely be billing your insurance company. **We strongly encourage you to call your insurance agency to discuss your coverage including your deductible status.**
4. **If your insurance company needs pre-certification or second opinion, it is your responsibility to notify us or your insurance company.**
5. If insurance payments leave you with a balance due on your account or if you have no insurance we will be happy to make payment arrangements for you.
6. All accounts which are past due for 120 days or more will be reviewed and possible collection action will be taken.
7. If you are applying for Disability/ Medicaid, due to the length of time required to receive these funds, you should be making monthly payments on this account, and if assistance is received, you should notify us immediately, so that we can file for benefits.
8. We accept all major credit cards and personal checks.
9. We charge co-pays, deductibles, and coinsurance at time of service. It is your responsibility to know your cost prior to appointment. If you have any questions or need any diagnostic codes please feel free to call.

Signature:	**Date:**

Cancelation Policy

Peak Cardiology understands that occasionally you will be unable to attend your scheduled appointment. When this happens we request a 24 hour cancellation notice. Failure to do so will result in the following **missed Appointment Fees:**

$ 25.00 Fee Office or Consultation Visit for Each Missed

$ 50.00 Fee Echo (Ultrasound) or Stress Echo Test

$ 200.00 Fee Nuclear Stress Test – Note: This charge covers the cost of medication that is delivered for your appointment, which cannot be returned nor used for a later date. This fee is only charged if you do not provide our office a 48 hour cancellation notice.

I have read and understand the cancellation policy stated and agree to accept responsibility as described.

Signature:	**Date:**