Hatfield CARDIOLOGY

Patient Information

Date:_____

Name:_____

DOB:_____ **Male** **Female**

Mailing Address:_____

City:_____State:_____Zip: Code_____

Primary Phone:_____ Cell/Work Phone:_____

Primary Care Provider_____

Referring Provider_____

Emergency Contact Information:

Name:_____Phone_____

Relationship_____

Would you like to be Web-enabled for our Patient Portal? **Yes** **No**

Email Address:_____

Pharmacy Information:

Name_____

Town:_____Street/Route_____

I give permission for Hatfield Cardiology to speak with my emergency contact regarding my medical information and office appointments (If **YES**, please sign below)

X_____

Patient Signature

Hatfield CARDIOLOGY

46 North Street, Suite 6 Hyannis, MA 02601 P: 508-778-4888 F: 508-778-4887

No Show / Same Day Cancellation Policy

Your appointment is important to us and to your health. If you miss an appointment, you may delay the treatment you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting, but our doctors are heavily booked and may not be able to reschedule you immediately.

Due to the number of patients waiting for appointments at our office, it is very important that you keep each appointment. We ask each patient to arrive 15 minutes prior to your scheduled appointment time, we do our very best to have the doctor or technician see you at your scheduled appointment time and provide you with the best care possible.

We understand that situations arise in which you must cancel your appointment. In consideration of others, we request that you call our office 24 hours in advance to cancel or reschedule your appointment to avoid the following charges ($25 office visit/holter monitor/ETT, $75 echocardiogram, $250 nuclear stress test). Situations such as medical emergencies occasionally arise, when an appointment cannot be kept and adequate notice is not able to be given, these will be considered on a case by case basis. Keep in mind most appointments are made months in advance, our office does provide appointment reminder calls two days prior to appointment, but this is a courtesy, ultimately remembering the appointment is the patients responsibility.

If you fail to keep an appointment without notifying the office in advance on three occasions, consecutive or otherwise, you will be dismissed from the practice. Please note: Same-day cancellations are also considered no shows.

We greatly appreciate your understanding and cooperation with this policy.

My signature below indicates that I have read the above policy and that I understand it.

Patient name:_____ Date of Birth _____

Patient/Guardian Signature: _____ Date: _____

Hatfield
CARDIOLOGY

Financial Responsibilities

You are responsible for knowing what your benefits are. In the event your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment.

Co-pays: Most HMO Health Plans have a co-payment per visit. Your insurance company sets the rate for co-payments. It is your obligation to pay the stated amount following each office visit.

Attendance Policy: If you must cancel your appointment, we ask you to call at least 24 hours in advance. You will be charged a **$25/office visit, $75/Echocardiogram, $250/Nuclear Stress Test** (Patient's initials_____) if you fail to cancel an appointment 24 hours in advance.

We have an answering service where you can leave a message if we are unavailable when you call.

I hereby assign all medical benefits to which I am entitled to Hatfield Cardiology, LLC. in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes collection service fees for unpaid balances over 90 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

Assignment of Benefits/Authorization to Release Medical Information & HIPAA Acknowledgement

I have read and fully understand Hatfield Cardiology, LLC's HIPAA policy. I understand that Hatfield Cardiology, LLC may use or disclose my personal health information for the purposes of treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practices's legal duties with respect to my information.

I understand that Hatfield Cardiology, LLC reserves the right to change the terms of it's Notice of Pravacy Practices, and to make changes regarding all protected health information resident ad, or controlled by, Hatfield Cardiology, LLC. If changes to the policy occur, Hatfield Cardiology, LLC will provide me with a revised notice upon request.

Print Name:_____ Date : _____

Signature: _____

_____

Name & Relationship to patient (if signed by a personal representative of patient)