Commonwealth Specialists of Kentucky

Welcome to our office!

Thank you in advance for completing these 4 pages of paperwork
in order to file insurance and maintain HIPAA compliance we must have complete and accurate information

PLEASE PRINT so we can enter correct information into the computer

PATIENT INFORMATION

Patient's Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. First: Last:	Sex M ☐ F ☐	Date of Birth _____/_____/_____	Social Security Number

Address:	City:	State:	Zip Code:

Daytime Phone: ( )	Cell Phone: ( )	Evening Phone: ( )

E-Mail Address (this will **ONLY** be used to send you a survey about your visit today)

Employer:	Business Phone: ( )

Emergency Contact Name:	Daytime Emergency Phone Number: ( )

Primary Care Physician: (include address and phone)	Referred By:

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company (if applicable):

Complete below ONLY if the subscriber of the insurance is NOT the patient.

Subscriber Name (**if not the patient**):	Phone Number: ( )	Relationship to Patient:

Subscriber Mailing Address: State: Zip Code:
City:

Subscriber Date of Birth: _____/_____/_____	Sex M ☐ F ☐	Subscriber Social Security Number:	Subscriber Employer:

Thank you for choosing us as your cardiology provider.

Bluegrass Cardiology Consultants

AUTHORIZATION FOR CONSENT FOR TREATMENT AND ASSIGNMENT OF PHYSICIAN BENEFITS

CONSENT FOR TREATMENT

I hereby consent to examination and treatment by Bluegrass Cardiology Consultants, including diagnostic and/or therapeutic procedures ordered by the physician. I understand that this consent covers all Bluegrass Cardiology Consultants satellite offices under common ownership. I acknowledge that Bluegrass Cardiology Consultants will use and disclose my medical and billing information only for the purpose of treatment and payment and healthcare operations.

PERSONAL BALANCE DUE

I understand that co-payments / co-insurance, as determined by my insurance company are due at the time of service. It is my responsibility to obtain any required referral authorizations required by my specific insurance plan. If the referral is not obtained prior to the visit, I understand that I will be liable for payment in full on the date of service. I acknowledge that any or all charges not covered by my insurance company are my responsibility to pay in full.

ASSIGNMENT OF BENEFITS

I authorize direct payment of benefits provided under any health care plan or medical expense policy due to me or payable on my behalf to Bluegrass Cardiology Consultants. I further authorize release of information required by any third party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third-party payor, as defined under my plan benefit contract, are my responsibility.

MEDICARE PATIENTS ONLY

Medicare Lifetime Signature on File

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

_____ _____

Medicare Patient Signature Date

AND

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Person Authorized to Consent **Date**

Bluegrass Cardiology Consultants

Permission to Communicate Privacy Information

I hereby give my permission for Bluegrass Cardiology Consultants to discuss any and all information concerning my health, account, medical services and payment records with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave a message about appointments, test results and/or billing information?

YES □, leave the message at (_____) _____.

NO □

I acknowledge that I have been given **Bluegrass Cardiology Consultants** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official, Chrystal Chaney.

Patient Signature: _____ Date: _____

Bluegrass Cardiology Consultants

279 King's Daughters Dr. Ste 204, Frankfort, KY 40601
Phone: 502-875-9885
Fax: 502-875-9882

Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

I_____, hereby authorize Bluegrass Cardiology Consultants and its authorized agents and employees to release or receive my medical records to any medical facility or physician who may need to utilize my records for medical treatment.

I understand that I have a right to revoke this Authorization, in writing, at any time, by sending such written notification to medical records personnel at the above-listed address. I understand that the revocation will not be effective to the extent that anyone has released my information pursuant to and reliance on this Authorization or if my Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____

Patient Signature **Date**