SOUTH MIAMI CARDIOLOGY, P.A.
7330 SW 62 PLACE, SUITE # 310
South Miami, Florida 33143

Date: ____________________

Social Security: ____________________

Patient Name: ______________________________ Date of Birth: ____________________

Address: ____

City: ____________________ State: __________ Zip Code: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Male: _____ Female: _____ Married: _____ Single: _____ Divorced: _____ Widowed: _____ Separated: _____

Student: __________ Full Time: __________ Part-Time: __________ Not a student: __________

Usual Provider: ____________________ Referring Physician: ____________________

Employer: ____________________ Work Phone: ____________________

Emergency Contact: ____

Telephone Number: ____________________ **Relationship:** ____________________

ACCOUNT INFORMATION:

Subscriber: __________ Self: __________ Spouse: __________ Other: __________

Name: ____

Address: ____

City: ____________________ State: __________ Zip Code: ____________________

Telephone Number: ____

Date of Birth: ____________________ Social Security Number: ____________________

Continue on Reverse >>>>>>>>>>>>>>>>

PRIMARY INSURANCE:

Primary Insurance Name: ______________________________

Address: ______________________________

____

Policy Number: ______________________________

Group Number: ______________________________

Effective Date: ______________________________

Telephone Number: ______________________________

SECONDARY INSURANCE:

Secondary Insurance Name: ______________________________

Address: ______________________________

____

Policy Number: ______________________________

Group Number: ______________________________

Effective Date: ______________________________

Telephone Number: ______________________________

**** We need a copy of your Insurance ID card and Drivers License.**

Thank you

RELEASE AND ASSIGNMENT: I hereby authorize South Miami Cardiology, P.A. to release to my insurance company or its representatives any information, including the diagnosis and the records of any treatment or examination rendered to me during such medical or surgical care. I also authorize my insurance company to pay directly to South Miami Cardiology, P.A. any allowances for medical care.

_______________________________ Witness

_______________________________ Signature of Insured

_______________________________ Signature of Patient

MEDIGAP ASSIGNMENT: I request that payment of authorized MEDIGAP benefits be made on my behalf to South Miami Cardiology, P.A. for any services furnished to me by South Miami Cardiology, P.A. I authorize any holder of medical information about me to release to _______________________ _________________________ any information needed to determine these benefits payable for related services.

_______________________________ Witness

_______________________________ Signature of Insured

_______________________________ Signature of Patient

I, the undersigned patient, understand that I will be financially responsible for any and all services ordered and /or performed by my attending physician.

In the event that these services are provided and not covered by my insurance plan, including Medicare, I hereby consent to have these services performed and agree for these services.

_______________________________ Signature of patient/responsible party

_______________________________ Date

South Miami Cardiology, P.A.

ROMEO A. MAJANO, M.D., F.S.C.A.I., F.A.C.C.
Board Certified in Internal Medicine, Cardiology, Interventional Cardiology, Vascular & Endovascular Medicine

MATTHEW E. SNOW, M.D., F.A.C.C.
Board Certified, Cardiology & Internal Medicine

JOSHUA A. HARRIS, M.D., F.A.C.C.
Board Certified in Cardiology, Internal Medicine, Nuclear Cardiology and Echocardiography

ERIC R. SCHROEDER, M.D.
Board Certified, Cardiology & Internal Medicine

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Name: ______________________________

Signature: ______________________________

Date: ______________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other ______________________________

7330 Southwest 62nd Place, Suite 310, South Miami, FL 33143 Tel 305-663-1001 Fax 305-663-1007

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name ______________________________

Address ______________________________

Telephone number ______________ Social Security number ______________

SECTION B: To the Patient – Please read the following statement carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we sill issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain

You may obtain a copy of our Notice of Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: ______________________________

Address: 7330 SW 62 Place, Suite #310

South Miami, FL 33143

Telephone Number: (305) 663-1001

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ______________________ Date: ______________________

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MEDICAL RECORDS RELEASE

Date: ______________________

To: ______________________ From: ______________________
Physician/Hospital

Phone Number: ______________________ Fax Number: ______________________

I hereby authorize and request you to release my medical records/testing results to:

South Miami Cardiology, P.A.
7330 SW 62 Place, Suite #310
South Miami, FL 33143

Patient Name: ______________________

Date Of Birth: ______________________ S.S. #: ______________________

Witness if unable to sign: ______________________

Relationship to patient: ______________________

Signature: ______________________