COLLINS CARDIOLOGY

1400 Peterson Ave. N. Douglas, GA 31533 T (912) 384-6276, F (912) 389-1618

Dr. Darrel Collins, DO Tara Spivey, PA

REGISTRATION FORM

Patient Information

Date:_____ Primary Physician:_____ Preferred Pharmacy:_____

Legal Name: (Last)_____ (First)_____ (Middle)_____

Date of Birth: _____ Age:_____ Gender: Male ☐ Female ☐

Race: Asian☐ Black or African American☐ Black Hispanic or Latino☐ Native Hawaiian/Other Pacific-Islander☐

White☐ White Hispanic or Latino☐ Refused☐ Unknown☐

Ethnicity: Hispanic☐ Non-Hispanic☐ Refused☐

Mailing Address: _____ City:_____ State & Zip Code:_____

Street Address:_____ City:_____ State & Zip Code:_____

Social Security Number: _____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Email Address: _____

Occupation:_____ Full Time ☐ Part Time ☐ Employment:_____

Employer Address: _____ Phone: _____

Legal Guardian: _____ Phone: _____

Marital Status: Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Name of Spouse:_____ Phone: _____

2nd Phone: _____ E-mail: _____

Insurance Information

Primary Insurance Plan: _____ Insurance ID: _____ Group No: _____

Primary Insurance Provider: _____

Secondary Insurance Plan: _____ Insurance ID: _____ Group No: _____

Secondary Insurance Provider: _____

Other:

Emergency Contact

Full Name: _____

Street Address:_____ City:_____ State & Zip Code: _____

Relationship To Patient: _____

Home Phone: Cell Phone: Work Phone:

Insurance Authorization and Payment Assignment

I hereby authorize this office to furnish any information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. Furthermore, I agree to settle any unpaid bills or to make arrangements for prompt payment of the unpaid account. And, I agree that a copy of this authorization shall be valid as the original. I have read and understand the above terms and conditions.

Signature: _____ Date:_____

For Medicare Patient Only

Name of Beneficiary/Patient: _____

Medicare No.: _____

Authorization and Payment Assignment:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Darrel Collins for any services furnished me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits payable for related services. I have read and understand the above agreement.

Signature: _____ Date:_____

COLLINS CARDIOLOGY

Patient Medical History

PLEASE COMPLETE THIS FORM BEFORE YOUR APPOINTMENT!!

******Bring all current medications to your appointment including vitamins, herbal medications and any over the counter medications you may be taking. ********

Date of Appointment:_____

Patient Name:_____Date of Birth/Age _____

Allergies: Drugs and reaction:_____

Food (e.g. Seafood, Shellfish) _____

Latex Yes No Iodine/x-ray dye Yes No

Risk Factors:

Tobacco use? Yes Never Quit **Year Quit**_____

If yes – **Type:** Cigarettes Cigars Pipe Chewing **How many per day?**___ **How many years?** ____

Street Drugs___Yes___ No_____

Diabetes? Yes___ No___ Year Diagnosed_____

High Cholesterol? Yes ____ No ___ Year Diagnosed_____

Hypertension? Yes __ No__ Year Diagnosed _____

Family History of Coronary disease before 60 yrs of age Yes _____ No _____

Mark if you have ever had or currently have the following and the year.

Blood Clots_____ Heart Attack_____

Sleep Disorder/Apnea_____ Stroke/TIA'S_____

Tuberculosis_____ Chest Pain_____

Lung Disease _____ Rheumatic Fever_____

Asthma _____ Thyroid disease_____

Heart Murmurs_____ Peripheral Vascular Disease _____

Kidney Disease_____ Blood Transfusions _____

Cancer _____ Hepatitis _____

Other_____

_____

Operations (Surgeries) or Hospitalization with dates

_____

_____

_____

_____

Family Cardiac History: (cardiac/vascular history such as: Heart attack, bypass surgery, congenital heart problems, sudden death, arrhythmia, congestive heart failure, stroke, stents in legs or heart, pacemaker, Diabetes, etc.)

Father: ☐ living ☐ deceased Age? _____

History _____

_____

Mother: ☐ living ☐ deceased Age? _____

History _____

_____

Brothers____ Ages _____

History _____

_____

Sisters____ Ages _____

History _____

_____

Social History

Marital Status_____

Employed ☐ Retired ☐ Disabled or

Occupation _____

Children Sons_____ Daughters_____

Diet ☐Regular ☐Special_____

Alcohol consumption: Yes_____ No_____

Amount_____

Exercise: ☐Regular ☐Occasional ☐Sedentary

☐Active lifestyle ☐Unable

Please list previous cardiac procedures with dates:
(Stress test, EKG, Echocardiogram, Heart Cath, etc.)

_____

_____

_____

PLEASE CHECK ONLY WHAT IS A CURRENT OR LONG STANDING PROBLEM:

Central Nervous System	*Comments*	*Skin & Breasts*	*Comments*
☐ Seizures		☐ Breast lump	
☐ Lightheadedness		☐ Change in color of mole	
☐ Vertigo(spinning)		☐ Sores that won't heal	
☐ Decreased alertness		☐ Numbness & tingling	
☐ Migraine headaches		☐ Itchy skin	
☐ Unilateral weakness		☐ Rash	
☐ Frequent headaches		***Kidney/Bladder***	
☐ Unsteady walk		☐ Urinary frequency/burning	
☐ Trremors/convulsions		☐ Blood in urine	
☐ Difficulty with speech		☐ Prostate problems(males)	
Eye, Ears, Nose & Throat			
☐ Vision problems			
☐ Hearing loss		***Musculoskeletal***	
☐ Ringing in ears		☐ *Joint pain/swelling*	
☐ Sinus problems		☐ Swelling of feet/ankles	
☐ Frequent colds		☐ Joint stiffness	
☐ Unilateral loss of vision		☐ Muscle weakness	
☐ Difficulty swallowing		☐ Pain in legs when walking	
Stomach/Intestine			
☐ Heartburn		***Respiratory (lungs)***	
☐ Indigestion		☐ Cough	
☐ Diarrhea		☐ Shortness of breath lying down	
☐ Diarrhea after meals		☐ Coughing up blood	
☐ Blood in stools		☐ Wheezing	
☐ Abdominal discomfort		☐ Shortness of breath at night	
Blood/Lymph Glands		☐ Shortness of breath	
☐ Abnormal bruising			
☐ Abnormal bleeding		***Psychiatric***	
☐ Swollen glands		☐ Anxiety	
		☐ Depression	
Endocrine		☐ Mood swings	
☐ Hotter/colder than others			
☐ flushing		***Miscellaneous***	
		☐ Fever/chills	
Allergies/Immunology		☐ Unusual wt gain/loss ____ lbs	
☐ Seasonal allergies		☐ Unusually tired	
☐ Frequent urination		☐ Loss of appetite	

PATIENT SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☒ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility	Collins Cardiology
Address	1208 Ocilla Rd. Douglas, Ga 31533 / 280 E. Willow Creek Ln. McRae, Ga 31055
Phone	912-384-6276
Fax	912-389-1618

The person named above hereby authorizes Collins Cardiology **to**

Name of Person, Provider, or Facility

- X Request health information from
- X Discuss health information with
- X Send health information to
- X Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name of Person, Provider, or Facility	
Address	
Phone	
Fax	

Scope

X All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify):

_____

X All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)

X Other information (specify):

_____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ (Signature of Patient or Authorized Representative) _____ (Date) _____ (Signature of witness) _____ (Date)

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

ATTENTION

You will be required to bring the following to ***EVERY*** appointment with our office:

1. All medications **IN THE BOTTLES**, including over-the-counter (OTC) medicines.
   - ***You can not be seen without all medications in their bottles. Lists are not acceptable.***
2. Insurance cards
3. Payment

Should you need to change or cancel your appointment date/ time, kindly call our office 24hours before your appointment.

Thank you for your cooperation and for choosing *Collins Cardiology*.

I understand and agree to abide by the policies stated above.

_____ _____

Patient/responsible party signature Date

*This document will be scanned into your permanent health record with Collins Cardiology

Collins Cardiology Financial Agreement

1. Payment is due at the time of service. You may be asked to pay old balances in full before an appointment can be scheduled.
2. If you have insurance coverage, please bring your insurance card(s).
3. All copayments, coinsurances and deductibles are required at the time services are rendered.
    - Every effort will be made by our office to work with you regarding financial arrangements and your budget.
4. We will file your claim to your insurance company for their portion. However, this does not exclude you from responsibility of the account. Whatever your insurance does not cover is your responsibility.
5. If you do not have insurance, you will be considered "self-pay." We have "self-pay" discounts in place for all of our services/procedures. At the time you a scheduled for a service/procedure, please feel free to ask what that charge with the "self-pay" discount in place. Charges for these services are also required up front.
6. Medicare patients are required by Federal Law to pay their co-payments, coinsurances and deductibles if there is no supplemental policy to pick up these balances after Medicare's payment.
7. Accounts with NO PAYMENT FOR 90 DAYS will be brought to the attention of the office manager. You will be asked to establish a payment arrangement.
    - Again, every effort will be made to establish a payment plan that fits your budget. Please cooperate with our office to help maintain a current account.
8. MISSED APPOINTMENTS – Please call and cancel/reschedule all appointments at least 24 hours prior so that we can offer this time slot to someone else waiting for medical treatment.
    - An excessive number of missed appointments not cancelled/rescheduled within a reasonable amount of time prior to your appointment could result in dismissal from the practice.
9. Thank you for choosing ***Collins Cardiology*** as your health care provider. We will make every effort to provide the highest quality of medical care to your or your loved one.

I have read and understand the above guidelines regarding Collins Cardiology's financial policies. I agree to abide by these guidelines.

_____ _____

Patient/responsible party signature Date

*This document will be scanned into your permanent health record with Collins Cardiology

COLLINS CARDIOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Collins Cardiology** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by **Collins Cardiology** describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at **Collins Cardiology**.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Collins Cardiology** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Collins Cardiology**.

With this consent, **Collins Cardiology** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Collins Cardiology** may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, **Collins Cardiology** may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that **Collins Cardiology** restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. **Collins Cardiology** is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Collins Cardiology** to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Collins Cardiology** may decline to provide treatment to me.

Print Patient Name: _____ Date of Birth: _____

Print Name of Legal Guardian, if applicable: _____ Relation: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Please list any authorized persons to receive medical information on your behalf:

1. Name: _____ Relationship to patient: _____

2. Name: _____ Relationship to patient: _____

3. Name: _____ Relationship to patient: _____