1174 E. Home Road
Springfield, Ohio 45503

Phone: 937-398-0354
Fax: 937-398-0358

Welcome to our Practice

Patient Information- Please Print				**Date**
Patient Name		**Birth Date**	**Age**	**SS#**
Street Address		**Home Phone #**		**Marital Status**
City/State/Zip Code		**Sex: Male/Female/ Other**	**Race**	**Language**
Email address		**Cell Phone #**		**Family Doctor**
Employed by		**Work Phone #**		**Family Doctor Ph #**
Primary Insurance		**Member ID #** **Group #**		
Secondary Insurance		**Member ID #** **Group #**		
Do we have your permission to leave confidential messages (phone or text) such as medicine changes and lab results on your phone? **YES** **NO**				
In case of Emergency Please Contact				
Name		**Phone #**		**Relationship**
Please list the family members or persons below, if any, who we may inform or contact about your medical health.				
Name		**Phone #**		**Relationship**
Name		**Phone #**		**Relationship**
Name		**Phone #**		**Relationship**

Spouse's Information (or Parent Information if under 18-year-old)			
Name	**Birth Date**	**Age**	**Sex: Male/Female/Other**

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, Springfield Cardiology (Ash Medical Inc. / Taj Medical Inc.) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to review the *notice of information practices* prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Springfield Cardiology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Springfield Cardiology reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Springfield Cardiology change their notice, they will provide you a revised copy upon your next scheduled visit to the office.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing this form, you acknowledge, understand, and accept the above information.

______________________________ ______________________________

Patient's Signature Date

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Financial Policy/Assignment of Benefits

Thank you for choosing us as your health care provider. We are committed to providing excellent health care services to you. As part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

*__It is your responsibility to provide us with your most current insurance information__.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim and you will be financially responsible for services rendered.
- Your insurance is a contract between you, your insurance and possibly your employer. It is your responsibility to understand the level of services covered by your insurance company. We may accept assignment of insurance after verification of your coverage and as a courtesy we will file an insurance claim for you. However, responsibility for payment by your insurance company rests with you. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance. **You are financially responsible for services not covered by your insurance company.**
- ***Co-payments are due at the time of service.*** If you fail to bring your co-payment, your appointment may be rescheduled.
- If you do not have insurance, payment in full for all services will be due at the time of service. If you are unable to pay in full at time of service a payment plan may be agreed upon.

* **It is your responsibility to provide us with your most current billing information.**

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our office within 30 days after receipt of the initial statement. A re-bill fee of $5.00 may be added to your balance for each additional monthly statement sent after the initial statement.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection costs incurred, including attorney’s fees and court costs if applicable.
- If you are unable to pay the balance in full, you must contact our billing office to discuss a payment plan. If you fail to make the agreed upon payments, your account may be referred to a professional collection agency. You will be responsible to pay a $25.00 collections cost incurred, including attorney’s fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance.
- You will be charged a $25 fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date, as of January 1, 2022.
- Failure to keep your account balance current may require us to cancel or reschedule future appointments.

*Financial responsibility for a minor rests with the adult accompanying the minor regardless of whose insurance covers the minor.

*We accept cash, check, money order, Discover, MasterCard, and Visa

I have read the financial policy as written above and understand and agree to this financial policy. I authorize payment of medical benefits to Springfield Cardiology (Taj Medical Inc,) and the release of any medical or other information necessary to process a claim for services rendered by Springfield Cardiology (Taj Medical Inc.)

____ __________________________________

Patient or Responsible Party Signature Date

____ __________________________________

Print Patient’s Name Patient’s Date of Birth