PASCO CARDIOLOGY CENTER, INC PATIENT INFORMATION

Mei Chang, M.D., F.A.C.C. Peter Rossi, M.D., F.A.C.C. Ali Dahhan, M.D., F.A.C.C. Scott Lee, M,D., F.A.C.C.

NAME:_____ **SEX : M / F**

ADDRESS:_____

CITY:_____ **STATE**:_____ **ZIP**:_____

********** If you maintain a Northern or Alternate address, please provide**********

ADDRESS:_____

DATE OF BIRTH:_____ **SOCIAL SECURITY #**:_____

HOME PHONE:_____**CELL**:_____ **MARITAL STATUS: S / M / D / W**

Can we leave a message on your answering machine or cell phone? Y / N

EMAIL ADDRESS:_____

EMPLOYED BY:_____ **WORK PHONE**_____

SPOUSE NAME:_____ **SPOUSE D.O.B**_____**SPOUSE SS #**_____

PRIMARY CARE DR:_____**REFERRED BY**:_____

PREFERRED PHARMACY:_____**Location/Cross St**_____

DESIGNATED RELATIVE

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

LIFETIME AUTHORIZATION AND ASSIGNMENT

I hereby authorize PASCO CARDIOLOGY CENTER, INC. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payments directly to Pasco Cardiology Center, Inc. For medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payments will be made to this physicians' office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare operations) with the above designated person/s.

PRIVACY NOTICE

I been informed of Pasco Cardiology Center, Inc.'s off ice privacy policy as required by HIPPA.

Signature:_____**Date:**_____

Patient Name: (PRINT):_____**Witness**_____