

# MIAMI CARDIOLOGY GROUP

Patient Information Form \_\_\_\_\_ Date \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex ( M/F ) \_\_\_\_\_  
Patient's Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Beeper \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Martial Status \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_ Who Referred You? \_\_\_\_\_  
Nearest Relative (If no spouse) \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Spouse \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Primary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company \_\_\_\_\_ PPO/HMO/IND (circle one)  
ID# \_\_\_\_\_ Subscriber #/Name \_\_\_\_\_

Secondary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company \_\_\_\_\_ PPO/HMO/IND (circle one)

**Consent For Treatment:** I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care of supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). \_\_\_\_\_ **(Initial)**

**Guarantee Of Account:** I understand that I am fully responsible for all charges made to my account. I hereby authorize **Miami Cardiology Group** to release any medication information necessary to process claims or any information requested from my records. I hereby assign payment of medical benefits to **Miami Cardiology Group** for services rendered as described. \_\_\_\_\_ **(Initial)**

**\*Medicare Lifetime Assignment:** I request that payment of authorized Medicare benefits be made to me or on my behalf to **Miami Cardiology Group** for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. \_\_\_\_\_ **(Initial)**

**\*Medicare And Medicaid Patient Certification- Patient Certification Authorization To Release Information And Payment Request:** I certify that the information given by me in applying for payments under Title XVIII and/or Title XIX, 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 or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance. \_\_\_\_\_ **(Initial)**

**\*HMO Disclaimer (Medicare Patient's Only):** I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this administration, due to current enrollment in an HMO Plan will constitute responsibility for payment of claim on my part. \_\_\_\_\_ **(Initial)**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Electronic Medical Records Storage:** To improve patient care, **Miami Cardiology Group** transmits certain portions of patients' medical records to Spectramedi, Inc. for electronic storage and retrieval. Spectramedi's electronic-based patient data enables your physician to continually improve the medical care provided to you and other patients.

I authorize **Miami Cardiology Group** to transmit portions of my medical record to Spectramedi. I understand that this information will be accessible by my physician, my physician's authorized staff, and authorized Spectramedi employees only. Spectramedi will secure my record from unauthorized access, and will not distribute patient-identifiable information to anyone except authorized individuals.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_