ADVANCED HEART AND VASCULAR ASSOCIATES

Nader Chadda, M.D., F.A.C.C., F.S.C.A.I. License #:ME104578

14100 Fivay Road, Suite 330• Hudson, FL 34667 • PH: (727) 859-7670 FX: (727) 491-5180

www.advancedhva.com

PATIENT REGISTRATION FORM

Today's Date:	Drivers license #:	**Age:**	**Date of Birth:**
Patient Name: (Last) (First) (Middle)		**Social Security #:**	Sex: ☐Male ☐ Female
Billing Address: Street / P.O. City State Zip			
Home Phone	**Cell Phone:**	Work Phone	
Email Address:		**Ht:**	**Wt:**

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other

Employment: ☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker

Primary Language: ☐ English ☐ Other:_____

Living with: ☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends

Marital status: ☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Insured's Employer:	Contact Person:	Office Phone:
Employer Address:		Fax Phone:

Guarantor/ Legal Guardian Information

Emergency Contact Name:	Relationship	Primary Phone:
Address:		Secondary Phone:
Power of Attorney Name:		**Phone:**

Pharmacy Information

Pharmacy Name:	Pharmacy Phone #:
Pharmacy Address:	

Insurance Information

Primary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

INSURANCE COPAY: _____ DEDUCTIBLE: _____

Secondary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

INSURANCE COPAY: _____ DEDUCTIBLE: _____

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FINANCIAL POLICY

Patient Name (*print name*):

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a large number of health plans, thereby making our services accessible to as many patients as possible. Please understand that in order to continue to provide outstanding services to our patients we need to maintain our administrative cost to a minimum.

Hereto is a summary of our financial and billing policies to identify clearly our processes, whereby your signature below acknowledges understanding of our financial policies outlined below:

1) FILED CLAIMS: the office will file all claims for services rendered to primary and secondary insurances. **It is the patient's responsibility to furnish accurate, complete and current insurance information.**

2) PAYMENTS: we file secondary insurance claims for all our patients. However, in many cases secondary insurances will pay patients directly or your insurance policy has deductibles, coinsurances or similar provisions that will result in a non-payment for balances after your primary insurance has paid a claim. **We reserve the right to bill any unpaid balances directly to the patient if no payment from a secondary insurance is received within 60 days after filing.** These balances are due in full from the patient at the time of statement receipt.

3) BILLING: questions regarding the billing process, charges on your account or to update or change information have to be addressed to the office in **care of Billing Department.** **Inquiries via phone should be directed to our office at 727-859-7670** , to avoid delays in processing.

4) CREDITS: In cases where patients pay an open balance and payment from a secondary insurance is received for the same claim, the office will refund any credits resulting from such payment to the patient provided the total credit balance is equal or greater than $20.00. Credit balances less than $20.00 will remain on the account and will be used towards future balances or refunded once the total credit amounts reach $20.00.

5) INSURANCE CO-PAYS: Because of the variety of different plans and contracts insurances have and the constant changes within each plan, we cannot be held responsible for the accuracy of co-payments collected. **In rare cases we have discrepancies between collected amounts and the amounts your insurance contract requires.** Adjustments of this nature will be made at the time the insurance notification is received and either credited to patient's account or billed to the patient.

6) COLLECTIONS: We try to work with patients to find ways to make the payment process as easy as possible. **However, if we do not receive payment after the stated grace period, accounts may be evaluated for further collection process and the office may consider discharging a patient from the practice for non-payment(s**).

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

PATIENT ACKNOWLEDGEMENT

By my signature below, I acknowledge to have read the above polices and agree to the terms outlines. I understand my responsibilities and the consequences for violation of the financial responsibilities. I was given opportunity to ask questions regarding the financial policies and understand their impact on my relationship to the practice.

Patient Signature:	Date:

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AUTHORIZATION FOR TREATMENT

Patient Name (*print name*):
I, the undersigned, hereby voluntarily consent to medical care / diagnostic treatment and/or minor surgical treatment by Advanced Heart and Vascular Associates deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any past/current medical records that are needed for my treatment from any prior healthcare providers and for information.

Patient Signature:	Date:
Witness Signature:	Date:

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CANCELLATION POLICY

Patient Name (*print name*):

You have been scheduled for an Ablation Surgical procedure with Nader Chadda, M.D. at our facility.

As it is our mission to provide the best service to our patients, we do enforce a 48 HOUR CANCELLATION NOTICE/ No Show Policy at our practice as we have patients who may at times be waiting weeks for their scheduled appointment.

Below is our NO SHOW /CANCELLATION Policy outline for your understanding:

1.) We request out of respect for other patients waiting for appointment(s), **please notify our office at least 48 Hours prior to your appointment date if you must CANCEL OR RESCHEDULE**. We are available to assist with rescheduling.

2.) If you do not contact our office, and are a **NO SHOW** at your scheduled procedure date/time you **WILL BE BILLED A $200.00 cancellation/no show fee** due to the cost involved for surgical preparation and supplies.

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

PATIENT ACKNOWLEDGEMENT

By my signature below, I acknowledge to have read the above cancellation/no show polices and agree to the terms outlined and understand the policies presented to me.

Patient Signature:	Date: