Metropolitan Cardiovascular Consultants
Ayim Akyea-Djamson M.D.,F.A.C.C.

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ M.I.: _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____ SSN# (optional): _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Ph: _____ Home Ph: _____ Work Ph: _____ Email: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced ☐ Other Race: ☐ White ☐ African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Mixed ☐ Other / ☐ Hispanic ☐ Non-Hispanic

Occupation: _____ Employer: _____ Work Address: _____

Primary Care Physician: _____ Referring M.D/Person:_____

Emergency Contact Information: I give permission to discuss my condition with persons listed below as need or in an emergency

#1 Name: _____ Relationship: _____ Phone: _____

#2 Name: _____ Relationship: _____ Phone: _____

Preferred Pharmacy:

Name: _____ Address: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____Member ID:_____ Group #: _____

Policy Holder First Name: _____ Last Name: _____ D.O.B.: _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance Company: _____Member ID:_____ Group #: _____

Policy Holder First Name: _____ Last Name: _____ D.O.B.: _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed plan and assign directly to Metropolitan Cardiovascular Consultants all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and will pay the balance if not paid by insurance in the allowed 60 days. I hereby authorize Metropolitan Cardiovascular Consultants LLC to release all information necessary to secure payment of benefits, including the diagnosis and records of any treatment or examination. I authorize the release of this information to third party payers, the physician's billing service and/or other health practitioners. I understand that unpaid balances may be turned over to a third party for collection. I authorize the use of this signature on all insurance submissions. I agree that all copayments,deductibles, or non covered charges will be paid at the time of service. This shall remain valid until written notice is given by me to the office revoking this authorization.

Patient/Guardian Signature: _____ Date: _____

Metropolitan Cardiovascular Consultants
Ayim Akyea-Djamson M.D.,F.A.C.C.

NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one more health care providers. An example of this would be a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. ● Health care operations include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 26,2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Policy and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Policies from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at 301-595-0356 with any questions you may have.
I acknowledge that I have received a copy of the Notice of Privacy Practices.

Printed Name	Signature of Patient or Guardian	Date

Metropolitan Cardiovascular Consultants
Ayim Akyea-Djamson M.D.,F.A.C.C.

DISCLOSURE CONSENT

Patient Name: _____ Date of Birth: _____

I wish to be called using the below number(s) regarding my test results, treatment plans, referrals and/or billing and payment information. The best telephone number(s) to reach me are:

Phone No: _____ ⚪Home ⚪Cell ⚪Work ⚪Other

Phone No: _____ ⚪Home ⚪Cell ⚪Work ⚪Other

⚪I DO give permission to leave relevant medical information on my answering machine or voicemail. ⚪I DO NOT give permission to leave relevant medical information on my answering machine or voicemail.

I authorize Metropolitan Cardiovascular Consultants, LLC to disclose my Protected Health Information either verbally or via phone, fax, email or paper copy to:

Name: _____ Relationship to Patient: _____

Address: _____Phone: _____

I understand that I have the right to revoke my permission at any time. I understand this permission remains in effect until the time I revoke it in writing.

Patient Signature: _____ Date: _____