COR HEALTHCARE MEDICAL ASSOCIATES

Appointment Date & Time: **PATIENT REGISTRATION**

PATIENT INFORMATION

Patient #:	Gender:	Date of Birth: Age:
Last Name:		PCP:
First Name:	Middle Initial:	Social Security #:
Marital Status:	__ Single __Married __Widow	Ethnicity: ____Hispanic ____Non-Hispanic ___Refused
Race: Please check one of the following: ____White ____Black/African American ____Asian ____Refused to Report ____Native Hawaiian or other Pacific Islander ____American Indian/Alaska Native		Preferred Language: ____English ____Spanish Other: _____
Address:		Home Phone: Cell Phone:
City, State, Zip:		Email:

EMPLOYMENT INFORMATION

Employer:	**Retired:** Retirement Date: _____
Address:	**Please check the following:**
City:	Disabled: **Yes** _____ **No** _____
State, Zip:	Unemployed: **Yes** _____ **No** _____
Work Phone:	

INSURANCE INFORMATION

Primary Insurance:	Insured Policy:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:
Second Insurance:	Insured's Name::
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Patient's Relation to Contact:
Contact Home Phone:	Contact Cell Phone:
Contact Work Phone:	

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Cor Healthcare Medical Associates to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., I hereby authorize Cor Healthcare Medical Associates to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

X_____ **Date:**_____

Signature

COR HEALTHCARE MEDICAL ASSOCIATES

HIPAA (Health Insurance Portability & Accountability Act)

Authorization for use and disclosure of Medical Information

In compliance with the HIPAA Patient Policy, this authorization allows COR Healthcare Medical Associates to release any of your protected medical information to the designated individual that you have specified.

I hereby authorize: COR Healthcare Medical Associates to release my medical information regarding my medical history and treatment by means of verbal communication in person, via telephone and/or mail and fax to the persons listed below.

1. _____( ) _____
   Phone Number
2. _____( ) _____
   Phone Number
3. _____( ) _____
   Phone Number

I wish to be contacted in the following manner (please check all that apply):

___ Home Telephone: ( ) _____
- ___ Leave message with detailed information on answering machine device, or anyone who answers
- ___ Leave message with a call back number only.

___ Work Telephone: ( ) _____
- ___ Leave message with detailed information on answering machine device, or anyone who answer.
- ___ Leave message with a call back number only.

___ Cell Number: ( ) _____
- ___ Leave message with detailed information on voice mail or anyone who answers.
- ___ Leave message with a call back number only.

___ Written Communication
- ___ Mail to my home address.
- ___ Mail to: _____

_____

___Other/**FAX:** ( )_____

Patient Name: **D.O.B:** **Date:**

I have been advised of my right to receive a copy of this authorization. A photocopy or fax of this authorization shall be considered as effective and valid as the original.
I understand this authorization will be in effect until which time it is revoked.

_____ _____
Signature of Patient or legal/personal representative Relationship

COR HEALTHCARE MEDICAL ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:

Patient Name: D.O.B.:

Patient Telephone Number: ( ) _____

I hereby authorize the following medical information to be released, which may include any information relating to cardiac, physical history, condition, advice or treatment.

Please furnish dates of specific records required: _____

_____

FROM:
Name: _____

Address/City/State/Zip: _____

_____

Telephone Number:_____

TO:
Name: _____

Address/City/State/Zip: _____

_____

Telephone Number:_____

Signature: _____Date:_____
Authorization Expires One Year from the Signed Date

Frequently Asked Questions
"Provider-Based" or "Hospital Outpatient" Billing

Torrance Memorial Medical Center has converted many of its physician clinics to hospital-based outpatient clinics. Depending on a patient's specific insurance coverage, it is possible that some benefits may differ for these services and procedures. Patients are advised to review their insurance benefits or contact their insurance provider to determine what their policy will cover and identify any out-of-pocket expenses. Below are frequently asked questions (FAQ's) related to this change:

Q: What does "Hospital-based Outpatient" mean?

A: Hospital-based outpatient clinics are considered a part of the hospital whereas "private" physician offices are not. Clinics that are located miles away from the main hospital may still be considered a part of the hospital. Hospital-based outpatient clinics are subject to stricter government rules. When you see a physician or receive services in a hospital-based outpatient clinic, you are being treated within the hospital rather than the physicians office.

Q. How does "Provider Based" or "Hospital Based Outpatient" affect my billing?

A: When seeing a Torrance Memorial Medical Center healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Previously, all services were provided by the physician office and charges were grouped together on your physician billing statement. Under "Provider Based" status, will be billed in two parts. When your medical services are completed, Torrance Memorial will submit a claim to Medicare for:

- Facility fee--- Part A

COR Cardiology Clinic will submit a claim for:

- Healthcare Provider fee--- Part B

You will receive two Medicare Summary Notices (MSNs) from Medicare. Once Medicare has processed their portion of the charges, the balance will be submitted to a secondary payor. If there is a balance after the secondary insurance processes the claim, or if you do not have secondary insurance, you will receive a bill for the remaining balance.

Please note: The total cost of charges for Medicare patients will not exceed charges incurred by non-Medicare patients receiving the same services.

Estimate of Charges

Medicare requires that we provide you with an estimate of your Part A and Part B coinsurance amounts. These amounts will vary based on the type and number of services received.

Estimate of coinsurance amounts:

	Part A	Part B
Office Visit	$10 to $26	$2 to $37
Radiology	$20 to $40	$2 to $12
Minor Procedure	$10 to $50	$5 to $10

Certain tests and procedures have higher coinsurance amounts due to their complexity.

Q: Why does the Medicare Secondary Payor (MSP) Questionnaire need to be completed?

A: As a participating Medicare provider, Torrance Memorial Medical Center is required to screen Medicare patients according to the Medicare Secondary Payor (MSP) rules. At each visit, you will need to answer MSP questions. These

questions help to confirm if Medicare or another payer should process the claim as primary.

Q: Does this apply to patients with private insurance like Blue Cross Blue Shield, United Healthcare, Cigna or Aetna?

A: Many private insurance companies do not follow the same billing rules require by Medicare and Medicaid, and therefore, do not recognize hospital-based billing.

Q: Does this mean I will pay more for services?

A: Depending on your specific insurance coverage, it is possible benefits may differ for certain services and procedures at provider based/hospital clinic locations. Making informed healthcare purchasing decisions is important. We recommend patients review their insurance benefits or contact your insurance provider. Ask if your benefit plan covers facility charges in a hospital-based outpatient clinic and how much of the charge is covered or will be applied to your deductible.

Q: What can patients do if they are having difficulty paying for healthcare services?

A: They can contact a Patient Account Specialist at **(310) 784-6950** to discuss available options. Torrance Memorial is committed to providing you with the highest standard of medical care. Thank you for choosing us as your healthcare provider.

Q: Where are the Torrance Memorial provider-based or hospital outpatient clinics located?

A: The following locations are licensed Torrance Memorial outpatient clinics:

- COR Cardiology Clinic, Torrance Memorial Specialty Center 2841 Lomita Blvd, Suite 100 Torrance, CA 90505
- COR Cardiology Clinic- 520 N. Prospect Ave, Suite 300 Redondo Beach, CA 90277

I have read the foregoing and understand that I may incur a liability to the hospital for Medicare coinsurance.

_____

Signature of Patient/ Authorized Representative

_____

Date Time

_____

Witness