RGG
RIHNER, GUPTA & GROSZ
CARDIOLOGY, P.C.

600 Providence Park Drive East
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Phone: (251) 634-1544
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PATIENT REGISTRATION FORM

WELCOME TO OUR OFFICE

****PLEASE PRINT****

Date _____ Primary Physician _____ Ethnic Background _____ Language of Choice _____

Patient's Name: Last _____ First _____ M.I. _____

Address: _____ City: _____ St: _____

Zip: _____ Home Phone # ( ) _____ Work Phone # ( ) _____ Email: _____

D.O.B. _____/_____/_____ Sex: M F Marital Status: M S D W DP S.S. # _____/_____/_____

Employer: _____ Occupation: _____

(Spouse, Parent or Guarantor)

Name: _____ Employer: _____

Occupation: _____ Work Phone # ( ) _____

D.O.B. _____/_____/_____ Sex: M F Marital Status: M S D W DP S.S. # _____/_____/_____

NEAREST RELATIVE OR EMERGENCY CONTACT*** (not in same household)

Name: _____ Phone # ( ) _____

Address _____

INSURANCE INFORMATION: (Please give copies of insurance cards)

Primary Insurance: _____

Policy #: _____ Group #: _____

Eff. Date ___/___/___ Address: _____ City: _____ St: ____ Zip: _____

Insured Name: _____ D.O.B. ___/___/___ S.S. # _____/____/_____

Patient's Relationship to Insured: Spouse • Child • Other Insured's Sex: M F

Secondary Insurance: _____

Policy #: _____ Group #: _____

Eff. Date ___/___/___ Address: _____ City: _____ St: ____ Zip: _____

Insured Name: _____ D.O.B. ___/___/___ S.S. # _____/____/_____

Patient's Relationship to Insured: Spouse • Child • Other Insured's Sex: M F

(OVER)

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or his/her authorized representative, do hereby authorize Rihner, Gupta & Grosz Cardiology, P.C. to release to my insurance company(ies) or other authorized agency(ies) that information which is necessary to validate my claim. Rihner, Gupta & Grosz Cardiology, P.C. is also authorized to release to my physician(s), either as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to Rihner, Gupta & Grosz Cardiology, P.C. The medical provider will file insurance claims on your behalf, but is not an insurer of said claims, and it is the patient/responsible party's duty to handle all matters with his or their insurance company in reference to payment of claims.

The undersigned understands that they are fully responsible for the charges associated with the treatment, and further agrees that in the event this account is placed for collection, that I/they will be responsible for all collection charges, including a reasonable attorney fee and interest. Outstanding balances will accrue interest at the rate of 1 1/2% per month. The undersigned also waives any rights which he/she/they may have according to the Constitution and Laws of the State of Alabama, or any other state, to claim exemptions as to personal and/or real property as provided by the Constitution and Laws of the State of Alabama, or any other state.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made on my behalf for any service furnished me by Rihner, Gupta & Grosz Cardiology, P.C. including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

MEDICAID PATIENT SIGNATURE

I hereby authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medical fiscal intermediary, the Medical Services Administration and/or to any other parties who may be liable for any of my Medicaid expenses.

AUTHORIZATION TO RELEASE MEDICAL REPORTS (INFORMATION) TO CONSULTING PHYSICIANS

I hereby authorize Rihner, Gupta & Grosz Cardiology, P.C. to release any medical information to physicians other than original referring physicians, who may be involved in my or my child's health care treatment, when requested by these physicians.

By signing this consent, information will be given to requesting physician without further signed authorization.

CONSENT FOR MEDICAL SERVICES

Permission is hereby granted to the authorities of Rihner, Gupta & Grosz Cardiology, P.C. for such medical procedures as may be deemed necessary by my attending physician, or whosoever he or she may designate.

RESPONSIBILITY FOR PERSONAL PROPERTY

I understand that Rihner, Gupta & Grosz Cardiology, P.C. does not assume RESPONSIBILITY FOR PERSONAL PROPERTY.

I acknowledge that I have read: **Notice of Privacy Practices/Notice of Individual Rights** and I have read all the above assignments, policies and procedures and agree to the same.

DATE	SIGNATURE OF PATIENT	SIGNATURE OF SPOUSE

DATE	SIGNATURE OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP	WITNESS