



# CIVA

THE CARDIOVASCULAR SPECIALISTS

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_

First Middle Maiden Last

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: [ ] Male [ ] Female

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
Month Day Year

Patient Employer: \_\_\_\_\_ Patient Occupation: \_\_\_\_\_

### SPOUSE OR LEGAL GUARDIAN INFORMATION

Spouse/Legal Guardian Name: \_\_\_\_\_

First Middle Maiden Last

Spouse/Legal Guardian Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
Month Day Year

Spouse/Legal Guardian Employer: \_\_\_\_\_ Spouse/Legal Guardian Occupation: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

[ ] Check box if same as spouse/legal guardian noted on previous page. If different, please complete information below.

Emergency Contact Person: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: [ ] Male [ ] Female

### INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder's Social Security No.: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

Secondary Insurance Company: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder's SS#: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

### CANCELLATION POLICY

Appointments must be cancelled at least 24 hours in advance. You will be charged for appointment not cancelled at least 24 hours in advance. Insurance companies do not cover this expense. This will be the sole responsibility of the patient.

**We have contracted with several insurance carriers to be providers for their PPO and/or HMO plans. Contractually, both the provider and the patient have certain obligations under these plans. We appreciate your cooperation and help in these matters. However, charges for all professional services rendered are ultimately the patient's responsibility.**

**We ask for your co-pay, co-insurance, and/or deductible at the time of your visit. After your insurance carrier has paid their portion, any remaining amount not covered due to co-pay, co-insurance, deductible, or non-covered services such as preventative care, etc., will be your responsibility and we will send you a statement indicating the amount due. The amount is due in our office within 10 days.**

**CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS**

- I consent to the treatment necessary for my care by a CIVA physician, nurse practitioner and/or physician assistant.
- I authorize the release of all medical records to the referring and family physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 21 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations to Medicare assignment of benefits also apply.
- I further authorize and request that insurance payments be directed to CIVA.

**I have read, fully understand, and agree to the above consent for treatment, financial responsibility statement, release of medical information, and insurance authorization.**

---

Date \_\_\_\_\_ Patient/Responsible Party or Guardian Signature \_\_\_\_\_

Please Print Name

**HIPAA AUTHORIZATION**

**Please check all that apply.**

- I authorize CIVA to use the contact information, phone numbers, and e-mail address listed on the front of this form to discuss or disclose information regarding any matters relating to my appointments, insurance, physician referral information, and lab results.
- I authorize CIVA to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, physician referral information, and lab results.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- I authorize Cardiology Research Institute of Dallas, an affiliate of CIVA, to review my CIVA medical records to determine if I qualify for a medical study. (If you are accepted into a study, medical care during the course of the study may be provided to you at no cost.)
- I acknowledge receipt and review of this Notice of Privacy Rights, and give permission to Cardiology and Interventional Vascular Associates to use and disclose my health information in accordance with it.

---

Date \_\_\_\_\_ Patient/Responsible Party or Guardian Signature \_\_\_\_\_

Please Print Name