AIC

ASSOCIATES IN CARDIOLOGY, PA

REGISTRATION INFORMATION

Patient Name: Last	First	Middle		Date of Birth	
Home Address	Apt. #	City		State	Zip Code
Home Phone	Cell Phone	Marital Status	Sex	Occupation	
Emergency Contact	Relationship			Telephone	
Referred By / Primary Care Physician		Your E-mail Address			
Race (please circle): African/American (Black) ; White; Hispanic/Latino; Native American; Asian or Pacific Islander; Answer Declined		Ethnicity: Hispanic/ Not Hispanic/ Prefer Not to Say (CIRCLE ONE)		Preferred Language	
Preferred Pharmacy:		Pharmacy City, State		Pharmacy Phone	

E-PRESCRIBING PBM CONSENT FORM

E- Prescribing is the ability to electronically send an accurate and understandable prescription directly to a pharmacy. In order to e-prescribe, we need to obtain your permission to access your prescription history from a Pharmacy Benefits Manager via Surescripts, our prescription vendor.

Formulary Benefit data is maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. Some PBM's that you may be aware of are Express Scripts and CVS Caremark. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need to access your data as maintained by the PBM's to know what medications have been prescribed to you in the past and to know which drugs are covered by your insurance plan.

By signing this form, you are agreeing that Associates in Cardiology, P.A. can access your pharmacy benefits data electronically through Surescripts.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Signature Date

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PATIENT ACKNOWLEDGEMENT/CONSENT FORM
USE AND DISCLOSURE OF HEALTH INFORMATION

Associates in Cardiology's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's notice of privacy practices by signing your consent at the bottom of this page.

Our notice of privacy practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail or when revisiting the office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

I wish to have the following restrictions on disclosure of my health information

_____

_____

_____

By signing this form, you consent to use our use and disclosure of protected health information about you for treatment, payment, and health care operations. These disclosures may be made by fax. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I fully understand and accept the terms of this consent.

_____ _____

Patient/guardian signature Printed Name

_____ _____

Date Date of Birth

AIC

Associates in Cardiology P.A

P: (301)-681-5700 2900 Linden Lane Suite 200 Silver Spring MD 20910 F: (301)-681-5599

SCHEDULING POLICY

All medical appointments once scheduled are considered reserved and confirmed. If you are enrolled for text or email reminders you will receive an automated message confirming your appointment once scheduled. Additionally you will receive a follow up call, text and/or email confirming your appointment three (3) business days prior to your appointment. Please make sure that we have your current contact information at each visit. If you would like to enroll in text or email reminders please speak with someone at the front desk. These messages only serve as a courtesy reminder of your scheduled appointment.

It is ultimately your responsibility to arrive to your appointment as scheduled. If you are unable to make your appointment we require 24 hour notice. In the event of a missed appointment:

- Stress Test and ultrasound appointments- **$100 cancellation fee**
- Office Visit- **$50 cancellation fee**

This charge will be applied to your account and must be paid prior to rescheduling your appointment.

We understand that there may be extenuating circumstances which may require you to cancel your appointment with less than 24 hour notice. We ask that you contact us as soon as possible to discuss your situation.

Our goal is to provide ample appointment times for all of our patients. Not keeping a scheduled appointment prevents someone else from being seen at that time.

Thank you for your consideration

By signing below you are acknowledging you have read and understand the Scheduling Policy as stated above.

Signature: _____

Print Name: _____

Date: _____

Updated 11/2021