OCEAN STATE
CARDIOVASCULAR & VEIN CENTER

Ocean State Cardiovascular & Vein Center, LLC

Patient Registration

Please Print:

Patient Name _____ Male_____ Female_____
Street Address _____
City_____State_____Zip_____
Date of Birth_____ Home Phone:_____ Contact Phone:_____
Social Security Number_____ Employer Name_____

Person to Notify in Emergency_____Phone#_____Relationship_____

Primary Care Physician's Name & Address:

_____

Name **Address**

Referring Physician's Name & Address:

_____

Name **Address**

Insurance Coverage

Name of Primary Insurance Company_____
Policy Number_____ Group Number_____
Subscriber_____ Date Of Birth_____
Relationship_____

Do you have a secondary insurance carrier? _____Yes _____No

If Yes, Name of Secondary Insurance Company_____
Policy Number_____ Group Number_____
Subscriber_____ Date Of Birth_____
Relationship_____

Please provide us with your insurance card(s) and picture ID so we can make a photocopy. Thank you.

HEALTH HISTORY

OCEAN STATE
CARDIOVASCULAR & VEIN CENTER

NAME: _____ Date of Birth: _____

Referring Physician Name/ Address/ Phone Number:

_____

Reason for appointment: *(circle all that apply)*

Referral: _____

Chest Pain/Angina	Heart Attack	High Blood Pressure	Coronary Artery Disease
Shortness of Breath	Abnormal Test/ EKG	Congestive Heart failure	Atrial Fibrillation
Dizziness/Passing out	Palpitations	Pre-Op Evaluation	CABG/Valve Surgery
Heart Murmur	Valve Replacement	DVT	Stent/Angioplasty
Hospital Follow Up	Varicose Veins	Pain/Swelling in Legs	Spider Veins

Other illness:

Diabetes	High Cholesterol	Emphysema/COPD	Kidney Problems	Anxiety/ Depression
GERD /Ulcers	Stroke/CVA/TIA	Asthma	Hyperthyroidism	Hypothyroidism
Pacemaker	Seizures	Other: _____		

Allergies:

Allergy to iodine contrast? __Yes __ No

Latex? __ Yes __No

Current medications: *(Please include name, dose and frequency)*

Name	Dose	Frequency

Do you take aspirin daily? ___ Yes ___ No **81mg / 325mg**

Smoking: ___Never ___Quit _____Year? ___Current Smoker: ____Packs a day for ____yrs.

Alcohol use (How often): ___ Never___ Social ___ 2-3 times per week ___ More than 3 times per week

Family history of cardiac disease or stroke: _____

Please list any recent testing related to reason of visit: *(include date and location)*

_____

_____

Please list all surgeries or procedures *(include hospital and date)*

191 Social Street, Suite 100, Woonsocket, RI 02895 Phone: 401-597-6500 Fax: 401-597-6509

OCEAN STATE
CARDIOVASCULAR & VEIN CENTER

Billing Procedures

1. I authorize the release of medical information to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize my insurance company to pay benefits directly to Ocean State Cardiovascular and Vein Center, LLC, which would otherwise be payable by me. I understand that I am financially responsible for charges not covered by my insurance carrier.

2. I understand if I have Medicare or Plan 65. Ocean State Cardiovascular and Vein Center will accept their payments in full. If you have Medicare with a private secondary insurance carrier, we will process the claim for you if the correct billing information and forms are provided. If you have Medicare without a secondary insurance, you will be billed for the 20% copay not covered by Medicare. You are responsible for your Medicare deductible not covered by your secondary insurance carrier.

3. Payment or Copay is required for all services at the time they are rendered unless you previously entered a payment plan with our billing company. You will be billed for any balance not paid by your insurance carrier or if your insurance carrier does not respond to our request for payment within 30 days. To facilitate collection of overdue accounts, where special arrangements have not been made, we will send all accounts over 90 days old to collections.

4. If you do not have insurance and are a self- pay, payment for office visits or testing will be due at the time service is rendered. Ocean State Cardiovascular and Vein Center has the right to reschedule or cancel testing if payment is not received at the time of appointment.

5. Nutritional counseling is not a covered service by insurance carriers.

6. Ocean State Cardiovascular and Vein Center reserves the right to charge the following for any missed or canceled appointments without 24 hour notice.

Office Visit: $25 Cardiac/Vascular Testing $50 Nuclear Stress Testing $200

7. If your insurance requires a referral from your primary care physician, we will help to acquire the referral prior to your appointment. If there is no response from your primary care physician and the referral is not received by our office within 5 days of your appointment, you may be billed for the cost of the appointment.

By signing this form, you acknowledge and agree to all of the above.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Printed Name Relationship to Patient

191 Social Street, Suite 100, Woonsocket, RI 02895 Phone: 401-597-6500 Fax: 401-597-6509

OCEAN STATE
CARDIOVASCULAR & VEIN CENTER

Acknowledgement of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices from Ocean State Cardiovascular and Vein Center, LLC and understand that if I have any questions regarding this notice I may contact Ocean State Cardiovascular and Vein Center at 191 Social Street, Suite 100, Woonsocket, RI 02895. Phone 401-597-6500.

By signing this form, you are granting consent to Ocean State Cardiovascular and Vein Center, LLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Printed Name Relationship to Patient

Record of Disclosure

The HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also is provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted by (please check all that apply):

____ Home Telephone # _____

____ OK to leave message with detailed information ____ OK to leave a message with call back number only

____ Work/Cell Telephone # _____

____ OK to leave message with detailed information ____ OK to leave a message with call back number only

Verbal Release of Information

I also indicate below the names of any person(s) to whom I would like Ocean State Cardiovascular and Vein Center to allow disclosure of my health information. Please specify the type of information that may be disclosed, such as lab tests, appointment information, prescription information, etc. You may indicate "ALL" if appropriate.

Name: _____ Relationship: _____ Type of information: _____

Name: _____ Relationship: _____ Type of information: _____

Name: _____ Relationship: _____ Type of information: _____

Name: _____ Relationship: _____ Type of information: _____

I understand that Ocean State Cardiovascular and Vein Center will continue to rely on the information on this form when communicating with others involved in my care unless I request changes. I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and the revocation will not apply to information that has already been disclosed prior to receipt of written revocation.