MARYLAND CARDIAC CARE
THOMAS H. WANG, MD, FACC

TEL (301) 337-9766
FAX (240) 715-9125
9715 Medical Center Dr., Suite 202
Rockville, MD 20850
www.marylandcardiaccare.com

Office Use Only: Account # _____

NEW PATIENT DEMOGRAPHIC FORM

Please print clearly

Patient Name _____
LAST FIRST MIDDLE

Address _____

City _____ State ____ Zip _____

Social Security # ____-____-____ Date of Birth (MM/DD/YYYY) ____/____/____

Sex ____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____

Home Phone # (____) _____ Cell Phone # (____) _____

Preferred Contact ❑ Home ❑ Cell Email _____

Patient Employer _____ Work Phone # (____) _____

Authorized Contact _____ Relationship to Patient _____

Home Phone # (____) _____ Cell Phone # (____) _____

Emergency Contact (if different) _____ Phone # (____) _____

PHYSICIAN INFORMATION

Referring Dr _____ Phone # (____) _____ Fax # (____) _____

Primary Care Dr _____ Phone # (____) _____ Fax # (____) _____

INSURANCE INFORMATION (Please allow us to scan your insurance cards)

Primary Insurance _____ Policy Holder/Guarantor: _____
Policy Holder Date of Birth _____ Policy Holder SS # ____-____-____
Insurance ID # _____ Group # _____

Secondary Insurance _____ Policy Holder/Guarantor: _____
Policy Holder Date of Birth _____ Policy Holder SS # ____-____-____
Insurance ID # _____ Group # _____

Patient Signature _____ Date _____

PLEASE HAVE YOUR INSURANCE, RX CARD, AND PICTURE ID AVAILABLE WHEN CHECKING IN.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Maryland Cardiac Care, LLC will not use this information for marketing research or solicitation of any kind. Your protected health information (PHI) is for the sole purpose of treating you, the patient.

Please complete the following information:

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # (____) _____ Cell Phone # (____) _____

Date of Birth (MM/DD/YYYY) ____/____/____ Social Security # _____-_____-_____

I authorize Maryland Cardiac Care, LLC to release my medical records, lab and echo reports, and/or billing records, for the purpose of treatment, payment, and healthcare operations (TPO) only.

I understand Maryland Cardiac Care, LLC will not release any other information without first seeking authorization from me.

I authorize Maryland Cardiac Care, LLC to (please check all appropriate responses):

❑ Send my billing information to my home address

❑ Be contacted by text or phone to confirm appointments

❑ Leave a voicemail message confirming appointments

❑ Leave message at the above phone numbers to give updates on medication and/or treatment

❑ Discuss TPO with the following designated person or persons: _____

I understand that this authorization is voluntary, and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

Signature of Patient or Representative: _____ Date: _____

If Representative, relation to patient: _____

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PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are committed to providing you with high quality care and to forming a relationship with you that is built on trust. We understand that information about you is private and we are committed to protecting this information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal information only for legitimate reasons.

This notice describes how your health information may be used and disclosed by us, your rights with regards to your health information, and our duties to protect such information. It applies to all records of your care that we maintain. Whether this information is stored in writing, on computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality.

Uses and Disclosures of your Health Information

This section describes how we use and disclose your health information. Below, we have listed the types of uses and disclosures that we may make. Any use or disclosure that is not listed below will only be made with your written authorization.

Without Your Authorization

Your health information may be used and disclosed by us for the following purposes without legal permission. However, prior to making such disclosure that is not listed below will only be made with your written authorization.

Treatment, Payment and Business Purpose: We use and disclose your health information to enable us to provide treatment to you, obtain payment for your care, and manage and administer our practice. For instance, we may use and disclose your health information to your insurer, HMO, or other third party payer to obtain for the services that we provide you. As another example, in consulting with a specialist regarding your health care treatment, we use and disclose your information. As a further illustration, we may use and disclose your health information to review the adequacy and quality of the care that you receive. As another example of managing our practice, we may use and disclose your information to create de-identified information to enable us to study our treatment patterns and the care that we provide.

Individuals Involved in your Care or Payment Notifications: We may disclose your information to your family members or friends who are involved in your care or who assist you in paying for your care. If we need to notify family and/or friends of your medical condition and/or location, we may also disclose your information. This notification may be via a disaster relief effort, such as the American Red Cross.

ACKNOWLEDGEMENT OF PRIVACY NOTICE REPORT

I have been provided a copy of the Notice of Privacy practices for Maryland Cardiac Care, LLC with an effective date of February 1, 2022.

Signature of Patient or Representative: _____ Date: _____

If Representative, relation to patient: _____

Office Use Only: Account # _____

MARYLAND CARDIAC CARE

PATIENT WAIVER FORM

❑ Referral Acknowledgement

I understand that if my insurance carrier determines that a referral is necessary, I am required to obtain a referral from my Primary Care Physician (PCP) prior to going to a specialist.

If I do not have a referral on the date of service, I understand and agree that I will be financially responsible for all charges that are not covered by my insurance company for this visit. I understand in some instances my PCP may approve a retro referral before initial billing activity takes place, and this referral follow-up is my responsibility.

❑ Primary Care Physician Acknowledgement

I understand that if my insurance company requires that I select and visit a Primary Care Physician (PCP) as part of my insurance plan coverage, but I have not selected a PCP and do not have a referral for my visit, then I will be financially responsible for all charges that are not covered by my insurance company for this visit.

❑ Acknowledgement that insurance may not cover services

I understand that my insurance may not cover all services. I understand that I will be financially liable for any services performed that are not covered by my insurance.

Patient's Name: _____

Signature of Patient or Representative: _____ Date: _____

If Representative, relation to patient: _____