

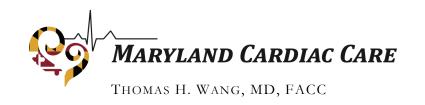
TEL (301) 337-9766 FAX (240) 715-9125 9715 Medical Center Dr., Suite 202 Rockville, MD 20850 www.marylandcardiaccare.com

Office Use Only: A	Account #
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### **NEW PATIENT DEMOGRAPHIC FORM**

Please print clearly		
Patient NameLAST	FIRST	MIDDLE
Address		WIIDDLL
City		<del></del>
Social Security #	Date of Birth (M	M/DD/YYYY)/
Sex Marital Status: ☐ Sir	ngle □ Married □ Divorced □	☐ Widowed ☐ Other
Home Phone # ()	Cell Phone # (	)
Preferred Contact ☐ Home	□ Cell Email	
Patient Employer		Work Phone # ()
Authorized Contact	Relationship to F	Patient
Home Phone # ()	Cell Phone # (	)
Emergency Contact (if different)		Phone # ()
PHYSICIAN INFORMATION		
Referring Dr	Phone # <u>()</u>	Fax # <u>()</u>
Primary Care Dr	Phone # ()	Fax # ()
INSURANCE INFORMATION (F	Please allow us to scan your ins	urance cards)
Primary Insurance	Policy H	Holder/Guarantor:
		lolder SS #
		oup #
Secondary Insurance	Policy F	Holder/Guarantor:
Policy Holder Date of Birth		Holder SS #
Insurance ID #		#
Patient Signature	Da	ate

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



Please complete the following information:

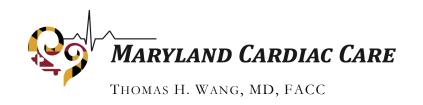
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# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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.

Name			
Address			
		Zip	
Home Phone # ()		_ Cell Phone # ()	
Date of Birth (MM/DD/Y	YYY)//	Social Security #	
		ease my medical records, la ment, payment, and healthca	•
I understand Maryland ( seeking authorization fr		not release any other inforn	nation without first
l authorize Maryland C	Cardiac Care, LLC to	(please check all appropri	ate responses):
☐ Send my billing inform	mation to my home ad	dress	
☐ Be contacted by text	or phone to confirm ap	ppointments	
☐ Leave a voicemail m	essage confirming app	pointments	
☐ Leave message at th	e above phone numbe	ers to give updates on medic	ation and/or treatment
☐ Discuss TPO with the	e following designated	person or persons:	
		ry, and that I may refuse to s in treatment, receive payme	•
Signature of Patient or	Representative:		Date:
If Representative, relation	n 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	e been provide	d a copy of the	Notice of Privacy	/ practices fo	r Maryland	Cardiac Care	e, LLC with	ar
effect	tive date of Feb	ruary 1, 2022.						

Signature of Patient or Representative:	_ Date:
If Representative, relation to patient:	

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## **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: