Pioneer Valley Cardiology Associates

EPIC MRN: _____

We'd like to welcome you as a new patient! Please take the time to fill out this form as accurately as possible so we can give you the best service. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). We will ask you questions about your race, gender identity, and health. We do this because we want to know and assist you as a person, and believe that your identities are important and vital to your health.

Legal Name: _____ Date of Birth: _____

Relationship/Marital Status: _____ Sex at Birth: _____ SSN: _____

Street Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Preferred Contact? ☐ Home ☐ Cell Email: _____

Preferred Language: _____ Race: _____ Are you Hispanic or Latino? ☐ Yes ☐ No

Are you FLUENT in English? ☐ Yes ☐ No *If no, an interpreter will be booked for any stress testing you may have.*

Are you hearing impaired? ☐ Yes ☐ No Are you visually impaired (beyond needing glasses)? ☐ Yes ☐ No

Referred by: _____ Name of Practice: _____

Primary Care Physician: _____ Name of Practice: _____

Do you have a Health Care Proxy or Living Will? ☐ Yes ☐ No If so, who? _____

Primary Insurance Coverage: _____ Subscriber ID: _____

Subscriber: ☐ Self ☐ Other (name & relationship): _____

Secondary Insurance Coverage: _____ Subscriber ID: _____

Subscriber: ☐ Self ☐ Other (name & relationship): _____

Employer of Subscriber: _____

TO NOTE: While this clinic recognizes and advocates for all gender identities, many insurance companies and legal entities do not. Please understand that the legal name and sex at birth listed on your insurance must be used on this document as it pertains to insurance and billing. If your name and pronouns are different from these, please include below so we know your name and pronouns. Our staff are here to make your visit as comfortable and respectful as possible, and we will use the name and pronoun you list.

Gender Identity: _____

Preferred Name: _____ Preferred Pronouns: _____

Pioneer Valley Cardiology Associates

General Consent and Authorization Form

EPIC MRN:

_____

Patient Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT

I hereby consent to the administration of treatment deemed necessary by my physician(s) and other physicians who may attend me, their associates and assistants, healthcare professionals responsible for my care, Pioneer Valley Cardiology Associates and any of its affiliates to provide medical care, tests, procedures, drugs or drug products, services, and supplies considered advisable by Pioneer Valley Cardiology Associates.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures, or examinations, while in PVCA. I am aware that, except in limited situations (such as a medical emergency), I am required to sign separate consent forms should I need to undergo surgery.

X _____ **Date:** _____

Signature of patient or responsible party

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

In order to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENT'S RESPONSIBILITY. As a patient of Pioneer Valley Cardiology Associates, you are hereby agreeing:

- **To pay all non-insured charges**, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of services or when otherwise advised. **If this is not possible, you agree to contact our business office BEFORE services are rendered.**
- **To provide us with a copy of your most recent insurance card** or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at time of EACH service, you agree to personally pay all **unpaid charges.**
- **To obtain any authorization required by your insurance plan for our services** from your health insurance provider prior to each appointment. If you do not receive the required authorization, your insurer may not pay us for our services. In these cases **you agree to personally pay any resulting unpaid charges.** Our office will do everything possible to make sure that appropriate authorizations are obtained.
- **To monitor your insurance company's payment** of your account and, if unpaid within 60 days from the date of service **to contact them regarding non-payment, and to cooperate with Pioneer Valley Cardiology Associates to resolve the unpaid status of your account.**

Further, you agree that Pioneer Valley Cardiology Associates has the right to be paid for their services and you acknowledge:

- That unpaid bills older than 90 days from date of service may be turned to a debt collection agency or attorney for collection.
- That you may be held responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.

I authorize use of the information on this form for all insurance claim submissions. I hereby authorize the release of any pertinent information to any doctor, insurance company, adjuster, or attorney involved in this claim. I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill and I hereby assign to Pioneer Valley Cardiology Associates any insurance or other third party benefits available for health care services provided to me. If these benefits are not assigned to Pioneer Valley Cardiology Associates, I agree to forward to Pioneer Valley Cardiology Associates all health insurance and other third party payment that I receive for services rendered to me immediately upon receipt.

I have read, understand, and agree to the above provisions:

X _____ **Date:** _____

Signature of patient or responsible party

Pioneer Valley Cardiology Associates

FOR OFFICE USE ONLY
EPIC MRN:

Patient Name Printed: _____

Date of Birth: _____

VERBAL RELEASE OF INFORMATION

Pioneer Valley Cardiology Associates can give verbal information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record.

If you wish others, such as relatives or friends, **who ask** about your condition, the right to be **verbally informed** about your condition when they ask, please list the names of those people below.

I am authorizing the release of **verbal medical information** regarding my treatment, care, and updates on my condition to the following individuals:

List as Emergency Contact? Check One	NAME	RELATIONSHIP	PHONE NUMBER
☐ Yes ☐ No			
☐ Yes ☐ No			
☐ Yes ☐ No			
☐ Yes ☐ No			

- I understand that Pioneer Valley Cardiology Associates will continue to rely on the information on this form when communicating with family members or others involved in my care unless I request changes.
- I understand that I may revoke this authorization anytime.
- I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department at Pioneer Valley Cardiology Associates. The revocation with not apply to information that has already been disclosed prior to receipt of written revocation.
- I understand that the information disclosed may include matters regarding mental health, developmental disability, genetic information, alcohol and/or substance abuse, infectious diseases including HIV, AIDS/ARC, and/or sexually transmitted disease, abortion or domestic and/or sexual assault**. IF YOU DO NOT WISH SUCH INFORMATION TO BE DISCLOSED, PLEASE SIGN FORM WITH NO ONE LISTED.**

_____ _____

Signature of Patient or Guardian **Today's Date**