

GOLDMAN CARDIOLOGY GROUP
CONCIERGE CARDIOLOGY

Account #: _____ Status: _____
Entered: ____ / ____ / ____ By: _____

Patient Demographics

First Name _____ M.I. _____ Last Name _____ Suffix _____

Preferred Name/Nickname _____ Date of Birth _____ Social Security Number _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify Primary Language: _____

Patient Contact Information

Street Address _____ Unit/Apt/Bld # _____ City _____

State _____ Zip _____ Email Address _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Contact Preference: ☐ Mobile ☐ Home ☐ Work ☐ Email ☐ Other: _____

Emergency Contact Information

Name (First and Last) _____ Phone Number _____ Relationship to Patient _____

Provider Information

Primary Care Provider _____ Office Location _____

Office Phone _____ Office Fax _____

Primary Insurance: _____

Subscriber ID/Contract No: _____ Group Number: _____

Subscriber Name (as on card): _____ Subscriber DOB: _____

Secondary Insurance: _____

Subscriber ID/Contract No: _____ Group Number: _____

Subscriber Name (as on card): _____ Subscriber DOB: _____

Other Insurance: _____

Subscriber ID/Contract No: _____ Group Number: _____

Subscriber Name (as on card): _____ Subscriber DOB: _____

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By signing below, I acknowledge and agree to the following:

Assignment of Benefits & Financial Responsibility

I authorize payment of applicable insurance benefits directly to Goldman Cardiology Group and authorize the release of information necessary to process insurance claims. I understand that I am responsible for all copayments, deductibles, non-covered services, and charges denied by my insurance. If more than one insurance policy covers me and there is a dispute regarding primary coverage, I understand that I am personally responsible for payment of all charges until the matter is resolved.

Consent for Care Coordination

I consent to the use and exchange of my health information by Goldman Cardiology Group with other healthcare providers and entities involved in my care, payment, or healthcare operations, as necessary for treatment and coordination of services.

Consent to Communication

I authorize Goldman Cardiology Group to contact me regarding my care, including appointment scheduling and reminders, test results, care coordination, concierge services, and billing matters, using the contact information I have provided. This may include voice calls, voicemail messages, text messages (including automated messages), and email. I understand that I may request limitations or opt out of certain methods of communication at any time by notifying the practice.

Acknowledgment of Privacy Practices

I acknowledge that I have received, or have been offered, the Notice of Privacy Practices for Goldman Cardiology Group, which explains how my health information may be used and disclosed.

Patient Name (Print)

Patient/Guardian Signature

Date