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

Insurance Information

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: ____________________

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