HEART OF VIRGINIA CARDIOLOGY, P.C,

A Division of Physicians Care of Virginia, P.C.

PATIENT NAME: ________________________________ **DOB:** _________________ **MRN:** _______________

1. **CONSENT TO TREAT:** I hereby authorize the physicians and staff of Heart of Virginia Cardiology, P.C.,a division of Physicians Care of Virginia, P.C. ("Provider"), to perform and hereby consent to such medical treatment and examinations including diagnostic procedures, as may be, in the opinion of *my/the* patient's physician(s), deemed necessary and advisable. If *I/the* patient fails to follow the direction of the health care providers or to carry out the recommended follow-up medical care, *I/the* patient do so at my own risk.

2. **NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, testing or examinations.
I understand that the risks of treatment may include, but are not limited to, infections.

3. **DEEMED CONSENT FOR BLOOD TESTING:** I understand that, under Virginia state law, if a health care provider or a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. For example, exposure could occur due to an accidental needle stick. Patients who have a confirmed positive test result will be given the opportunity for individual face-to-face disclosure of results and appropriate counseling.

4. **ASSIGNMENT OF PAYMENT:** In consideration of medical services to be rendered to *me/the* patient or at *my/the* patient's request, I assign payment to Provider for medical service rendered to *me/the* patient or at *my/the* patient's request paid by my health insurance or liability policy, or other arrangements or plan with a third party that provides payment for medical or health care services or policy of insurance or from any settlement or judgment that comes from any related incident that caused the medical treatment. Pursuant to this assignment, I recognize and understand that if Provider has a contractual relationship with my insurer, Provider will bill my insurer and accept payment in accordance with that contractual agreement. If Provider does not have a contractual relationship with my insurer, I acknowledge and understand that Provider may choose not to accept assignment and/or not to bill my insurer directly. Without a contractual relationship I may be responsible for all service charges, regardless of any representations made by my insurer, and it will be my responsibility to seek reimbursement from my insurer. If I have any questions as to whether my insurer has a contractual relationship with Provider, I may direct those questions to PCV Central Billing Office.

5. **REFERRAL/AUTHORIZATION AND NON-COVERED SERVICES:** I understand that *my/the* patient's insurance, HMO or health benefit plan may require a referral and/or authorization prior to the delivery of this service. I also understand that *my/the* patient's insurance, HMO or health benefit plan may deny payment for services that are not covered or for which the patient is not eligible under the plan or coverage at the time the services are rendered or a determination under the plan or coverage that the services were not medically necessary. I acknowledge and agree that, in the event payment for these services is denied based on the provisions of *my/the* patient's insurance, HMO or health benefit plan, I am fully personally responsible for payment of charges for these services and will be billed directly.

6. **PROMISE TO PAY:** I understand that I owe and unconditionally agree to pay to Provider the full amount charged for the services rendered to myself, my child and/or any patient for which I am legally responsible that are not paid on *my/the* patient's behalf by a third party within sixty (60) days from billing of medical services rendered. I understand that separate bills may be generated for some services. Examples included but are not limited to: physician, diagnostic studies, laboratory, radiology, and/or anesthesia. Additionally, I agree to pay my insurance co-payment, co-insurance or known out-of-pocket expenses, at the time of service. I agree that if Provider must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered, I will pay to the extent permitted by law: (a) any and all costs incurred by Provider in pursing collection including, but not limited to, reasonable attorneys' fees; and (b) any court costs or other costs of litigation incurred.

7. **AUTHORIZATION FOR RELEASE, DISCLOSURE AND USE OF PATIENT INFORMATION (including protected health information):** I understand that Provider uses an Electronic Medical Record. I authorize Provider to obtain *my/the* patient's health information from other health care providers and health care facilities and to release *my/the* patient's health information to any physician involved in my treatment; any health care facility to which *I/the* patient is discharged, transferred and/or presents for treatment; health care providers or others for the purposes of treatment, payment and health care operations including but not limited to billing, healthcare management, discharge planning, quality assurance, bill collection, defense of litigation or anticipated litigation, and/or to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by our practice. I consent to the use, release and disclosure of *my/the* patient's protected health information for all the above reasons. I understand that my health information may be transmitted in electronic or paper format or verbally. I authorize to access and use my patient prescription information from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment and health care operations and that this practice is not required to agree to such a restriction request.

8. **MEDICARE LIFE-TIME SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment or authorized Medicare/Medicaid benefits be made on *my/the* patient's behalf for any services furnished by Provider. I authorize any holder of medical or other information about *me/the* patient to release to the Centers for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services and their agents any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to submit claims to Medicare and/or Medicaid for payment. I understand that I am responsible for any deductibles, co-payments and/or any applicable amount of remaining charges.

9. **CONSENT TO WIRELESS TELEPHONE CALLS:** If at any time I provide a wireless telephone number to the practice at which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages, automated reminders) at that wireless number from, its successors and assigns, and its affiliates, agents and independent contractors, including collection agents regarding the services rendered, and/or my related financial obligations.

10. **VALUABLES:** I understand that Provider will not be responsible for any valuables, money or other such personal property left unattended or retained by me/the patient. Accordingly, *I/the* patient assumes the risk of loss or theft of any personal property and agrees to hold Provider harmless from any and all liability which may result from the loss of any such personal property or valuables.

11. **ADDITIONAL PROVISION APPLICABLE FOR MINOR OR OTHER PATIENT FOR WHICH THE UNDERSIGNED IS LEGALLY RESPONSIBLE:** I, the undersigned, acknowledge and verify that I am the legal guardian, custodian or otherwise legally responsible for the patient.

12. **ACKNOWLEDGMENT:** I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS AND AGREE TO FOLLOW AND BE BOUND BY THEM. I certify that all information supplied by me, as part of the registration process is correct. By signing this form, I acknowledge that I have been offered and/or received the PHYSICIANS CARE OF VIRGINIA, P.C. Notice of Privacy Practices.

______________________________________ ____________________ __________
Patient Printed Name Date Time

______________________________________ ____________________ __________
Patient or Parent/Legal Guardian Signature Date Time

______________________________________ ____________________ __________
Witness Printed Name Date Time

______________________________________ ____________________ __________
Witness Signature Date Time

TODAY'S DATE_____________________

HEART OF VIRGINIA CARDIOLOGY

A DIVISION OF PHYSICIANS CARE OF VIRGINIA

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION (PLEASE COMPLETE ALL SECTIONS ON FORM)

FIRST NAME____ MIDDLE NAME_______________________________________

LAST NAME____________________________ PREFERRED NAME_____________________ SUFFIX (JR, SR, III)_________

ADDRESS____

CITY____ STATE___________ ZIP_________________________

HOME PHONE____________________ CELL PHONE___________________ EMAIL ADDRESS_____________________________

PREFERRED CONTACT METHOD ◻ HOME PHONE ◻ CELL PHONE ◻ WORK PHONE

DATE OF BIRTH__________________________________ AGE_____________ SEX ◻ MALE ◻ FEMALE

SSN____ PRIMARY LANGUAGE_____________________________________

MARITAL STATUS ◻ SINGLE ◻ MARRIED ◻ DIVORCED ◻ WIDOWED

RACE ◻ BLACK, AFRICAN AMERICAN ◻ ASIAN ◻ WHITE
◻ AMERICAN INDIAN, ALASKA NATIVE ◻ NATIVE HAWAIIAN, OTHER PACIFIC ISLANDER

ETHNICITY ◻ HISPANIC OR LATINO ◻ NOT HISPANIC OR LATINO

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME____________________________________ RELATIONSHIP TO PATIENT_____________________

EMERGENCY CONTACT PHONE________________________ EMERGENCY CONTACT SECONDARY PHONE______________________

EMPLOYMENT INFORMATION

◻ DISABLED (D1) ◻ HOMEMAKER (H1) ◻ RETIRED (R1) ◻ SELF EMPLOYED (S2) ◻ STUDENT (S1) ◻ UNEMPLOYED (U1)

EMPLOYER NAME____

EMPLOYER PHONE NUMBER____ EXTENSION______________________________

ADDRESS____

CITY____ STATE___________ ZIP_________________________

BILLING INFORMATION (WHO SHOULD RECEIVE BILLING STATEMENTS)

RELATIONSHIP TO PATIENT ◻ SELF ◻ SPOUSE ◻ PARENT ◻ OTHER

MAILING ADDRESS (IF DIFFERENT)____ P.O. BOX____________________

HOME PHONE NUMBER_______________________________ CELL PHONE NUMBER_____________________________________

PHYSICIAN INFORMATION

PRIMARY CARE PROVIDER OR FAMILY PHYSICIAN____

PHYSICIAN WHO REFERRED YOU TO OUR SPECIALIST____

HEART OF VIRGINIA CARDIOLOGY

A DIVISION OF PHYSICIANS CARE OF VIRGINIA

PATIENT INSURANCE INFORMATION

WE WILL SCAN YOUR INSURANCE CARDS EVERY OFFICE VISIT

PRIMARY INSURANCE

INSURANCE NAME____

GROUP NUMBER_______________________________________ POLICY NUMBER______________________________________

POLICY HOLDER NAME____ DATE OF BIRTH_______________________

SOCIAL SECURITY NUMBER______________________ POLICY HOLDER'S EMPLOYER NAME_____________________________

EMPLOYER'S PHONE NUMBER_____________________________________ EXTENSION_________________________________

SECONDARY INSURANCE

INSURANCE NAME____

GROUP NUMBER_______________________________________ POLICY NUMBER______________________________________

POLICY HOLDER NAME____ DATE OF BIRTH_______________________

SOCIAL SECURITY NUMBER______________________ POLICY HOLDER'S EMPLOYER NAME_____________________________

EMPLOYER'S PHONE NUMBER_____________________________________ EXTENSION_________________________________

TERTIARY INSURANCE

INSURANCE NAME____

GROUP NUMBER_______________________________________ POLICY NUMBER______________________________________

POLICY HOLDER NAME____ DATE OF BIRTH_______________________

SOCIAL SECURITY NUMBER______________________ POLICY HOLDER'S EMPLOYER NAME_____________________________

EMPLOYER'S PHONE NUMBER_____________________________________ EXTENSION_________________________________

LEGAL REPRESENTATION OF LIVING WILL, MEDICAL ADVANCE DIRECTIVE OR POWER OF ATTORNEY

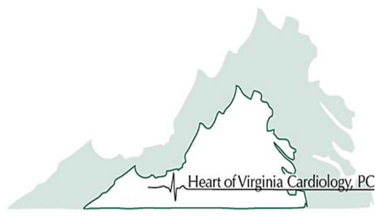
DO YOU HAVE A LIVING WILL OR MEDICAL ADVANCE DIRECTIVE? ☐ YES ☐ NO

ON FILE HERE? ☐ YES ☐ NO

DO YOU HAVE A POWER OF ATTORNEY? ☐ YES ☐ NO

ON FILE HERE? ☐ YES ☐ NO

IF SO, WHO? NAME______________________________________ RELATIONSHIP TO PATIENT_________________________



Insurance Protocol

If you have an insurance policy that requires a referral from your primary care physician, it is YOUR RESPONSIBILITY to obtain the referral prior to the visit.

- It is YOUR RESPONSIBILITY to follow your particular health plan protocol.
- Make sure the facility in which you scheduled an appointment accepts your insurance. Contact your insurance company to see if a referral is needed.
- If you are unsure, check with your primary care physician or call your insurance company for guidelines.
- If proper protocol is not followed, you may be responsible for all charges.

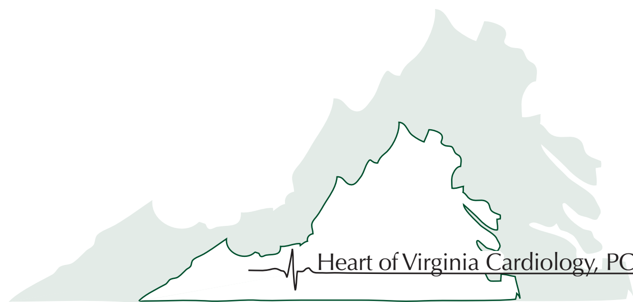
I acknowledge that I have been given a copy of Heart of Virginia Cardiology's Insurance Protocol effective August 1, 2016.

Thank you,
Heart of Virginia Cardiology

____________________________________ ________________________
Signature Date

____
Printed Name

____
Primary Care Physician



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Alan McLuckie, MD, F.A.C.C.

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F.A.C.C., F.S.C.A.I., R.P.V.I.

Elizabeth O. Hall, PA-C, MCMS

Emeritus
Frank England, MD, F.A.C.C.

Welcome to **Heart of Virginia Cardiology**. We are pleased that you have selected our services. On your first appointment, please arrive 30 minutes before you are scheduled. This will allow us time to complete your registration paperwork prior to your office visit.

Please complete the enclosed forms and bring them with you to your appointment.

Please bring:

1) Payments (co-pay) required by your insurance company.
2) Insurance cards, your driver's license or a photo ID.
3) List of your medications, amounts you take and how often you take each one.

Directions to Heart of Virginia Cardiology –

From Interstate 81:
Follow 419 South toward Salem/Roanoke. Stay on 419 South for 7 miles. Heart of Virginia Cardiology is on your left in an office complex called the McVitty Executive Center. There is a median on the highway here. You will have to pass by the office. There is a left turning lane a short distance past the office where you can do a U-turn to come back to the office complex entrance. We are the first building on the right when you turn in.

From the 581/220 Intersection with 419/Franklin Road (Tanglewood Mall):
Follow 419 North for 3 miles. We are located in an office complex called the McVitty Executive Center. You need to pass through two more traffic lights after going through the 419/Brambleton intersection. The office complex entrance will be another .2 miles on the right after this second light (just past the Mutual of Omaha building). We are located in the building to the right as you turn into the main entrance. Our office has a little copper covered porch roof. Welcome!

PCV

Physicians Care of Virginia, P.C.

A Physician-Owned Corporation

Manage Your Health Records
Online, Anytime.

- *Valley Nephrology Associates*
- *Heart of Virginia Cardiology*
- *Stephen L. Hill, M.D., F.A.C.S.*
- *Roanoke Vascular Access Center*
- *New River Valley Heart Clinic*

PCV is pleased to offer our patients the opportunity to join **Follow My Health**, a **free** patient portal that will give you internet access to summaries of your office visits, lab test results, immunizations, prescription details and allow you to securely message your medical office with appointment requests, appointment changes or to ask a general question.

Please provide us with your email address and an invitation to join will be emailed to you.

Patient Name: ________________________________ **Date of Birth:** ______________

Email address: ________________________________

* Must be 18 years or older to join. Please note that parents can obtain access to their child's records from birth to age 18.

☐ - I **want** to join FollowMyHealth and have my office visit summaries sent to my secure account.

☐ - I **want** to receive a paper copy of the visit summary and **will not** be joining FollowMyHealth at this time but I have received information on how to register in the future.

Signature: ________________________________ **Today's Date:** ______________

If you are acting on the patient's behalf, please print your name in the space below:

Name ______________________ **Signature** ______________________

Address ____

Phone Number ______________________ **Relationship to Patient** ______________________

Physicians Care of Virginia is a physician-owned, multi-specialty organization with practices currently in Roanoke, Martinsville and the New River Valley. Our practices include specialties in Nephrology, Cardiology, Gastroenterology, General Surgery and Vascular Access.