Cardiovascular Solutions of Central Mississippi
REGISTRATION FORM

Today's Date:	Primary Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status: Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No					Male / Female

Address: (Street Address, P.O. Box, City, State, and Zip Code)

Social Security no.:	Home phone no.:	Cell phone no.:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option): ○ Referred by:
○ Doctor:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:

Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY:

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Workphone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Cardiovascular Solutions of Central Mississippi

Patient's Name: _____

Date of Birth: _____

Today's Date: _____

Personal History: (Please circle the one's that pertain to you)

High Blood Pressure / High Cholesterol / Diabetes / Congestive Heart Failure / Coronary Artery Disease / Swelling in Extremities

Others: _____

Surgical History (with year): _____

Cardiac Procedure History: (Please Circle and indicate what year)

Heart Cath / Cardiac Stent / Peripheral Vascular / Coronary Artery Bypass Graft

Do you exercise? _____ How often? _____ What do you do? _____

How many pillows do you sleep on at night? _____

Have you ever seen a cardiologist before? Yes / No If yes, who? _____

Social History: (Please circle the ones that pertain to you)

Cigarette Use: yes / never/ quit Packs per day: _____ How many years: _____ Year Quit: _____

Alcohol Use: yes / never/ quit How often: _____

Chewing Tobacco: yes / never / quit

Street Drugs: yes / never / quit

Family History: (Please circle the one's that pertain to your family history and indicate the relationship)

Coronary Artery Disease: _____

High Blood Pressure: _____

High Cholesterol: _____

Heart Attack: _____

Stroke: _____

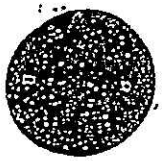
Others: _____

Medicine:

What Medicine are you allergic to: _____

Are you allergic to Shellfish or Iodine? Yes / No If yes, which one? _____

Pharmacy:



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Cardiovascular Solutions of Central Mississippi creates a record of the care you receive from us. This record is your health information. We are required by law to keep this information private. We are also required to provide you with notice so you will know how we use and release health information. This notice also lists the rights you have regarding your health information. We will abide by the terms of this notice.

We reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the health information we already have. When we make changes to the privacy practices, we will post an update in the clinic. You may also request a copy of this notice at any time.

How Cardiovascular Solutions of Central Mississippi may use and release your health information:

For Treatment: This includes calling or mailing you for reminders of appointments. Also discussing treatment alternatives or other health care related benefits that may be of interest to you as a patient.

To Obtain Payment for Treatment: We will release information to your insurance company in order to receive payment for your treatment.

For Health Care Operation: Administrative personnel reviewing the quality and appropriateness of the care you receive.

RIGHTS REGARDING YOUR HEALTH INFORMATION

- You have the right to request to get copies of your health information. You must make request in writing. We may charge you a fee based on our cost.
- You have the right to request a correction to your health information. If you believe that your health information is incorrect or if information is missing, you may request the information to be changed or added. You must make request in writing. Under circumstances, we may deny the request. If we deny your request, we will let you know the reason why in writing.
- You have the right to request a listing of releases we have made of your health information. Your request must be made in writing. Must state the period desired for the accounting, which must be less than a six month period. The list will contain the date of the release, the name of the recipient and the address, if known, a description of the information released and the reason for the release. If you make more than one request in the same year, you will be charged a fee on the coast of each additional request.
- You have the right to request limits on the use and releases of your health information. You may not limit the uses and releases that we are legally required or allowed to make.

- You have the right to choose how we communicate with you. We require you make the request for confidential communication in writing.

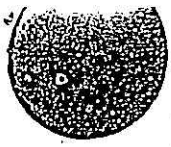
Use and Releases That Do Not Require Your Permission:

Emergencies Workman's Compensation* Federal, State or Local law* Government Agencies and Law enforcement* Public Health Concerns* Coroners, Medical Examiners and funeral homes* Health Oversight Reasons* Disaster Relief Reasons* Avert A Serious Health Threat To Health Or safety* Organ and Tissue Donation*Court Ordered* Food and Drug Administration or CDC.

YOU HAV THE RIGHT TO COMPLAIN TO CARDIOVASCULAR SOLUTIONS OF CENTRAL MISSISSIPPI OR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. To complain please call the Administrator at (888)757-0838.

I HAVE RECEIVED AND HAD AN OPPORTUNITY TO ASK QUESTIONS CONCERNING THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

PRINT NAME	SIGNATURE	DATE



Cardiovascular Solutions of
Central Mississippi

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Patients are expected to make payments in full for office services at the time of the visit. For your convenience, we accept cash, VISA and MasterCard. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements can be made. Patients who have insurance contracted with us are responsible for any co-payment or deductible at the time of service. Any balance remaining on the account after insurance payment have been received will become the responsibility of the patient. Accounts with delinquent balances could be reported to the credit bureau or turned over to our collection agency if little or no effort has been made by the patient to settle the amount owed.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize above office to use my medical information for treatment, payment, and healthcare operations, including submitting information to my insurance company for the purpose of processing claims. I permit the following to be used in place of this document for all federal, state, and private commercial health insurance claim:

1. Photocopy or other facsimile reproduction of this authorization, or
2. Use of computer to indicate my signature is on file at the above office, and/or
3. Use of a computer to transmit my insurance claim by phone for processing

PRINT NAME SIGNATURE DATE

CERTIFICATION/AUTHORIZATION OF INSURED: I certify that the insurance information I have provided to be true and correct to the best of my knowledge. I authorize payment for services rendered to the doctor associated with this office. I understand cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I understand that if my account should ever require action by a collection agency in order to collect the balances owed, fees charged by this agency may be added to the balance due on my account.

I authorize the doctor of the above office and its designees to provide treatment, I further authorize labs, radiology. Pathologists and radiologist who may interpret and report on diagnostic tests might bill separately. I authorize the above office to release all or part of my records to

1. Physicians to whom I am being referred, and/or
2. Any in- or out-patient facility where I and scheduled to receive treatment.

PRINT NAME SIGNATURE DATE

Cardiovascular Solutions of Central Mississippi

903 E. Sunflower Road
Suite 500
Cleveland, MS 38732
Phone: (888)757-0838
Fax: (888)796-1835

Date: _____

I, _____, hereby authorize confidential information to Dr. Foluso Fakorede and Cardiovascular Solutions of Central Mississippi.

Information requested: _____

_____

_____

_____

_____

_____

Patient: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

_____

Date(s) of Service: _____

Signature of patient or guardian: _____

Financial Policy

Cardiovascular Solutions of Central Mississippi financial policy requires our office to collect payment for your office care at the time services are rendered. We accept cash, cashier check, money order, and personal check, debit card, Master card, Visa. There will be a $40.00 fee charged to the patient on any returned check. We ask you to remember that the ultimate responsibility for full payment for our services rest with the adult patient or guarantor. If your account becomes delinquent, and it becomes necessary for the account to be referred to an attorney or collection agency or suit, the patient or guarantor will be responsible for paying all patient charges, reasonable attorney fees, collection expenses and court costs.

The undersigned agrees that any and all services of every kind or nature provided by Cardiovascular Solutions of Central MS, Pa. through any of its agents or employees (licensed or otherwise) shall be considered to constitute medical care and any action based upon the delivery of such services, or the failure to provide such services shall be governed by the provisions of document 11-1-60, et seq. and document '15-1-36, The Mississippi Medical Malpractice Reform Act.

Patient Consent for Use of Credit cards. Debit Card

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Cardiovascular Solutions of Central Ms. PA to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment. I will not challenge such credit, debit, or financing card payments once the services are provided.

In Clinic testing

In the interest of laboratory, pathology and diagnostic tests (up to date EKG) may be ordered and you are financially responsible for payment of these tests.

Insurance Deductibles (if applicable), co-payments (if applicable) are due at time of service. For your convenience, we accept Visa, Master card, or, you may pay cash, a personal check or cashier's check for payment. All copays and deductibles will be paid at the time of service.

Insurance

It is the policy of this office to collect the patient's deductible and out of pocket expenses at the time of appointment. For any in clinic testing covered by your insurance, we will submit a claim to your insurance company, and once the company has paid all it will pay on the claim, the adult patient (18 years of age or older), or guarantor is responsible for any remaining balance.
We participate in numerous insurance programs to accommodate our patients. While we are pleased to be able to provide this service, it is extremely difficult for us to keep track of all the individual plan requirements. Each plan has different policies regarding how often services may be rendered and, even more importantly, where those services may be performed. We ask you to inform us if your coverage has any special requirements, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. We have found that many insurance plans provide payment at levels significantly lower than our fees. We take great care in setting our charges well within the acceptable norms for similar services in this area. Insurance companies no longer abide by these norms rather they

establish their own reimbursement schedules. It is our desire that you receive the maximum benefit possible from your health insurance In order to achieve this we need your assistance in providing us complete and accurate personal and insurance information on the attached form.

Insurance Authorization and Assignment: I hereby authorize Cardiovascular Solutions of Central Ms. Pa to release information requested by my insurance company or workmen's compensation carrier. I also authorize Cardiovascular Solutions of Central Mississippi to release information to any hospital or physician to which I may be referred by this office. In addition, authorize Cardiovascular Solutions of Central Mississippi to request and obtain my medical records from my insurance company, workmen's comp carrier, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Cardiovascular Solutions of Central Ms. Pa from major medical benefits or legal settlements and/or judgments due me I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account in order to recover any uncollected balances.

Patient/Guarantor: _____ **Date:**_____

Medicare-Medicaid Certification: I authorize any holder or medical information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Cardiovascular Solutions of Central Ms. PA for services rendered me by its physician(s).

Patient/Guarantor: _____ **Date:**_____

Cancellation

As a policy, we ask that you contact our office at least 48 hours prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment to another patient. If you fail to cancel within 48 hours or do not show, there will be a fee incurred of $50 for a missed business opportunity which will be charged to your credit card that you submitted at the time your appointment was booked, we appreciate our patients and would like to thank you for your consideration of our policies. I understand that I am financially responsible for all services rendered, regardless of the availability of any insurance coverage(s). I have read and understand this explanation of the financial policy of Cardiovascular Solutions of Central Mississippi and agree to accept responsibility as described.

Patient/Guarantor: _____ **Date:** _____

HIPAA-Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge the receipt of Cardiovascular Solutions of Central Mississippi Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 888-757-0838 or by requesting one at the following office:

Patient/Guarantor: _____ **Date:** _____

Print Patient Name: _____ Date: _____

Photo Release:

I consent to the taking of photographs by Dr. Foluso Fakorede or his designee of me of parts of my body in connection with the procedure(s) to be performed by Dr. Foluso Fakorede. I, understand and consent to the photos being used for educational purposes only by Cardiovascular Solutions of Central Mississippi. I, give consent for any photo only to be released by the appointed designee on behalf of Cardiovascular Solutions of Central Mississippi, Dr. Foluso Fakoredeor Fusion Vascular on Company Facebook, Instagram page, Linked In or for any other educational purposes deemed by Dr. Foluso Fakorede. I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the healthcare services presently receive, or will receive, from Dr. Foluso Fakorede I understand that I have the right to inspect and copy the information that I have authorized to be disclosed, i further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation. I understand that the information disclosed, or some portion I, hereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPAA). I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination. Testing, credentialing and/or certifying purposes by the American Board of Cardiology Inc.I certify that I have read the above Authorization and Release and fully understand its term.

Patient/Guarantor: _____ Date: _____

_____ I consent for photo release (Initial)

_____ I do not consent for photo release (Initial)

Cardiovascular Solutions of Central Mississippi

903 E. Sunflower Road, Suite 500

Cleveland, MS 38732

888 757-0838

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Cardiovascular Solutions of Central Mississippi for your cardiovascular care.

We are pleased that you have chosen to seek your medical care with us. The staff at Cardiovascular Solutions of Central Mississippi strives to exceed expectations in care and services in order to make your experience with us a comfortable and stress fee. Please feel free to contact our office if you have any questions concerning our policies.

OFFICE HOURS

The office staff is available Monday through Thursday 7:30 am to 4:30 pm and Friday 8:00 am to 3:00pm (excluding holiday schedules and closures). The office may be reached at 888 757-0838 for routine matters such as appointment scheduling, prescription refills, and other non-emergency matters. An answering service is available to assist you after these scheduled office hours. In event of emergency, please call 911.

APPOINTMENTS

When calling for an appointment, please be prepared to provide any updated contact and insurance information. If you change your phone number, address, or insurance information, please contact our office at the time these changes occur.

While we strive to schedule appointments appropriately, emergencies can occur in specialty medicine and Dr. Fakorede will always give each of his patients the time required for their unique medical problems. For this reason, we kindly request your patience and understanding should delay or rescheduling be necessary on your appointment date.

PLEASE BRING ALL MEDICATION BOTTLES TO ALL APPOINTMENTS

It is the policy of this office that cancellations must be within 24 hours of scheduled appointments. All no show appointments are automatically rescheduled out for 2-4 weeks. Our office will contact you via phone and or mail to inform you of the new date and time. This is to prevent any lapse in patient care and for continuity of care. When a patient fails to cancel the office visit in a timely manner, our office staff resources, staff time, and equipment are wasted, and other patients are limited access to our services. If you have 3 consecutive no shows, you risk being discharged from the practice

If you no show a diagnostic procedure a $100.00 fee will be added to your bill. This includes all hospital and office procedures.

***Please be advised that no-show charges are patient responsibility and will not be billed to your insurance company

Insurance

As a courtesy to our patients, Cardiovascular Solutions of Central Mississippi will file insurance claims on your behalf. We accept most major insurance carriers. We do not accept Ambetter.

It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or a denial in insurance payments. If your insurance company does not pay for your charges, the balance becomes the patient's responsibility.

Patients are responsible for co-payments, co-insurance and deductibles at the time of service. If we are unable to verify insurance coverage prior to your scheduled appointment, the patient will be responsible for the cost of the office visit at the time of service.

Payments can be made by cash, personal checks and most major credit/debit cards.

FEES

Medical Records:

Per HIPPA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form of release of medical information must be completed prior to release of these materials. Any medical record that are requested by another physician's office will be faxed directly to that office at no fee. Medical records requested by other parties, such as insurance companies or attorney's offices will incur the following fees:

- Medical Records: $25.00
- State Disability claims: $25:00
- Patient forms including FMLA forms $10:00

Dr. Fakorede is happy to complete these forms. Please allow 7 days for completion of these forms

RECEIPT ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received, reviewed understand and will comply with the policies and procedures of Cardiovascular Solutions of Central Mississippi.

_____

Patient Signature

Date

Cardiovascular Solutions of Central Mississippi

903 E. Sunflower Road, Suite 500

Cleveland, MS 38732

888 757-0838

HIPPA CONSENT FORM

PATIENT NAME:_____

DOB:_____

HIPPA IS AN ACRONYM FOR THE Health insurance portability and accountability act of 1996

Of significant concern to healthcare organizations is the administrative simplification section of the ACT, which requires healthcare organizations to comply with the specific rules regarding:

- Unique identifiers for health plan, providers, individuals and employers
- Healthcare transaction and code sets for transmitting date electronically
- Privacy regulations over disclosure and use of health information
- Security regulation over protections of electronic health information

I understand that I have read the Notice of information Practices that provides a more complete description of the information uses and disclosures, posted in the lobby reception area. I understand that upon request I will be provided a copy of such notice. It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, cell phone with the exception of appointment reminders that reveal doctors name date and time only. In the instances when we are returning a phone call and have to leave a message with unauthorized person no information will be left.

If you wish to authorize us to leave and/or release information with someone other than yourself please complete the following information:

NAME:_____ PHONE:_____

NAME:_____ PHONE:_____

<u>Consent to use and disclosure of the health information for treatment; payment or healthcare operations</u>

I understand that as part of my healthcare, Cardiovascular Solutions of Central Mississippi originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communications among many healthcare professionals involving my care
- A source of information for applying my diagnosis and surgical information to my bill

- A means by which third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and receiving the competence of health care professionals

SPECIAL SITUATIONS: We may release medical information about you for public health activates such as prevent and control disease, injury, disability and driving etc.