Mountaineer Cardiology, PLLC
2345 Chesterfield Ave., Suite 302
Charleston, WV 25304
Phone: 681-205-8610
Fax: 681-205-8615
mountaineercardiology.com

John L. Goad, MD, FACC • S. Shawn Groves, MD, FACC • James J. Pettit II, MD
Jennifer Westfall, APRN-BC • Marsha Wiersteiner, APRN-BC • Stephanie Legg, APRN-BC

REGISTRATION FORM

Mr. Mrs. Ms. Dr. gender: M F or_____

Name: First_____ MI_____ Last_____

Age_____ DOB_____ Social Security#_____ Race____

Address_____ City_____ State_____ Zip_____

Phones: Home_____ Cell_____ Work_____

Ethnicity: Hispanic non-Hispanic or _____

Marital status _____ Email _____

Would you like an email introduction to our patient portal? Yes No

Preferred contact phone number _____

Emergency Contact _____ Phone _____

INSURANCE COMPANY

Primary_____ policy number _____

Name of insured _____

Insured DOB _____ Insured SS# _____

Patient relationship to insured: self _____ spouse_____

Secondary _____ policy number _____

Name of insured _____

Insured DOB _____ Insured SS# _____

Patient relationship to insured: self _____ spouse _____

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DOCTORS

Referring _____ Phone_____

Primary Care _____ Phone _____

PHARMACIES

Local _____ Phone_____

Mail Order _____ Phone _____

The **HIPPA Privacy Act** gives the individual the right to request confidential communication or that a communication of the protected health information be made by alternate means.

May we contact you by phone? Cell Home Work

May we leave a message? Cell Home Work

Please provide the name of any individuals to whom we may speak with regarding you and your care.

Name *Contact number* *Relationship*

_____

_____

CONSENT FOR ELECTRONIC TRANSMISSION OF RECORDS

I understand that in providing healthcare it may be necessary to electronically transmit certain medical information about my care. If it becomes necessary to electronically transmit protected health information, I authorize Mountaineer Cardiology, PLLC to do so. If another party in error receives this information, I absolve Mountaineer Cardiology, PLLC of any liability relating to such submission of records. Mountaineer Cardiology, PLLC will use all due diligence in order to prevent any accidental transmission or release of information.

_____ _____ _____

Signature of patient PRINT NAME Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I understand the Health Insurance Portability and Accountability Act (HIPAA) allow my health care providers the right to release my protected health information for treatment and payment purposes without my written consent. However, certain state and federal laws require consent from me before specially protected records can be released Therefore, I authorize Mountaineer Cardiology, PLLC. their our medical staff to release my protected health information when requested by any health insurance company/organization in order to process claims filed for office visits, or for benefit assessment. I also authorize the release of my medical information to other hospitals, facilities, physicians; including my primary care physician or referring physicians in order to facilitate my care.

I understand that signing this form permits the release of my complete health records.
Including, but not limited to; diagnosis, prognosis, treatment, counseling and or education related to drug/alcohol/tobacco abuse.

I understand that I may revoke this authorization at anytime in writing, except where action has already been taken upon this authorization. My revocation will not be effective until I submit a written request to revoke the authorization to the organization/provider who has been authorized to release my records associated with this authorization.

I have read this authorization or it has been read to me, and I understand the authorization I am granting by signing it. I understand that I have the right to inspect and copy any written information to be disclosed, and the right to properly revoke this authorization at any time. I understand that I have a right to a copy of this form. A copy of this Authorization will be considered the original copy.

This authorization shall be valid for one year from the date of signature, unless properly revoked.

_____ _____

Signature of Patient or Authorized Rep. Date/Time

CONSENT TO TREAT / PATIENT AGREEMENT

I understand that information that I give about myself to Mountaineer Cardiology, PLLC must be true and correct. I authorize Mountaineer Cardiology PLLC and their providers to bill and receive payment from my insurance company (ies). I will be responsible to pay all co-payments and or deductibles as required by your insurance company at my visit. I will get authorization from my insurance company for specialized services as required by my policy. I am responsible to pay all charges not paid by my insurance company. I consent to receive medical care provided by Mountaineer Cardiology PLLC, however I understand that I have the right to refuse any specific procedure or treatment. I understand it is my responsibility to let my doctor know what medicines that I am taking and further consent to providers obtaining my current and previous medication history from any pharmacies that I use and the WV Board of Pharmacy. I understand how important it is for my cardiac health to attend all of my appointments and testing scheduled with Mountaineer Cardiology PLLC and that there may be charges for no shows or no cancellation of visits within 24 hours of a scheduled appointment or procedure and may result in being charged in full for the procedure.

_____ _____

Signature of Patient or Authorized Rep. Date/Time

Patients Name: ______________________________ **DOB:** ____________________

MEDICATION LIST

Allergies: ____

Name of Med	Strength	Dosage	Health Issue