Thoracic & Cardiovascular Surgery, Inc.
Dennis J. Tishko, MD Kevin M. Radecki, MD

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Male/Female _____

***May we leave messages on your home recorder? ___ Yes ___ No * May we call your cell phone? ___ Yes ___ No**
*** May we contact you at work? ___ Yes ___ No * May we leave a voicemail message at work? ___ Yes ___ No**

Occupation _____Marital Status _____ Religion _____

Social Security # _____ Date of Birth _____ Age _____

Employed by/ Retired from: _____ Employer Phone # _____

Reason for Today's Appointment. Please indicate specific SIDE and location of problem or surgery:
_____

Allergies: _____

Medications:_____

_____

_____

Spouse's Name _____ Social Security # _____

Spouse Employed by/Retired from: _____ Employer Phone # _____

Family Physician _____ Phone # _____

Address _____City _____ State _____ Zip _____

Referring Physician _____ Phone # _____

Address _____City _____ State _____ Zip _____

Primary Insurance Company _____ Policy # _____

Secondary Insurance Company _____ Policy # _____

Emergency Contact (other than spouse) _____ Phone # _____

******PLEASE READ AND SIGN THE BACK OF THIS PAGE******

Information Reviewed _____ 2008 _____ 09 _____ 10 _____ 11 _____ 12 _____ 13 _____ 14 _____ 15 _____ 16 _____ 17 ____

Privacy Consent – for the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care facility.

I hereby give my consent to Thoracic & Cardiovascular Surgery, Inc. to use and disclose my protected health information (PHI) for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status / function or the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.
Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.
Consent related to the Privacy Notice: I have reviewed the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restriction. If the practice does not agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse providing services to me if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent the revocation does not take effect until the practice receives it.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Copy of Practice Privacy Notice signed or initiated with patient/guardian on _____

Patient unable to sign privacy statement due to _____

Consent for Assignment of Benefits and Office Policy on Payment: I consent to assign all payments for services provided to Thoracic & Cardiovascular Surgery, Inc. I understand I am responsible for all co-payments, amounts applied to deductible or other amounts deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I am responsible for the account balances as well as any collection fees, attorney, and court costs, should my account be sent to a collection agency. I further understand that my contract with my insurance entity may or may not cover some or all services. It is my responsibility to obtain information from my health plan information about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. I understand that my consent for assignment of benefits can be revoked but not the office policy on collection accounts.

Patient/Guardian _____ Date _____

Revocation: I hereby revoke the consent given above.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Revised: March 2008