CARTI

TO BE SCANNED
Scan-EMR

Demographics, Authorizations & Financial Responsibility

MRN#_____

First Name_____ MI_____ Last _____

Mailing Address_____City/State_____

County _____Zip_____ Home Phone #_____ Cellular _____

Work #_____ E-mail Address_____

Primary Care Physician_____ Cardiologist_____

Other Providers_____

Do we have permission to send you occasional e-mails/materials regarding CARTI publications and/or notification of CARTI patient programs, special events and giving opportunities? ❍ Yes ❍ No

Authorization to Disclose Treatment Related Information

- How would you prefer we communicate with you? ❍ Mail ❍ Phone ❍ Email
- Do we have your permission to text you with information about statements and payments? (you have the capability to opt-out at any point) ❍ Yes ❍ No
- Do we have your permission to leave a message/voicemail at the phone numbers listed above? ❍ Yes ❍ No
- Do we have your permission to discuss information pertaining to your diagnosis and continuing care with your family? ❍ Yes ❍ No
- Do we have your permission to discuss financials and statements pertaining to your diagnosis and continuing care with your family? ❍ Yes ❍ No

If yes: Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Marital Status:

❍ Single ❍ Married ❍ Divorced ❍ Widow ❍ Other (specify):_____

Date of Birth: _____ **Gender:** ❍ Female ❍ Male

Social Security Number: _____

Language Preference:

❍ English ❍ Spanish ❍ French ❍ German ❍ Other (specfy):_____

Race:

❍ Caucasian ❍ Pacific Islander ❍ Asian ❍ Hispanic
❍ Native American ❍ Black or African American ❍ Japanese ❍ Other, Undetermined
❍ Native Hawaiian ❍ American/Alaska Indian ❍ Filipino

Ethnicity:

❍ Hispanic or Latino ❍ Non-Hispanic or Non-Latino ❍ Other or Undetermined

Employment Status:

❍ Employed ❍ Not Employed ❍ Retired

Occupation:_____ **Employer:**_____

Primary Insurance:_____ Policy #:_____Group #:_____

Policyholder's Name:_____DOB: _____ Relationship to patient:_____

Plan address & telephone #:_____

Secondary Insurance:_____ Policy #:_____Group #:_____

Policyholder's Name:_____ DOB: _____ Relationship to patient:_____

Plan address & telephone #:_____

If Medicare is secondary, please complete the Medicare Secondary Payor Form (MSP)

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Financial Responsibilities, Assignment of Benefits and Authorization for use and disclosure of PHI:

- I have received a copy or been provided access to CARTI's Notice of Privacy Practices.
- I understand I am financially responsible for any balance due to CARTI, as assigned by my insurance after claims have been processed.
- I authorize CARTI to obtain any financial information if financial terms are requested.
- I authorize CARTI to receive payments from my insurance company or companies on my behalf, and to pursue those payments through administrative procedures if necessary.
- I authorize CARTI and my insurance company to release medical data including Private Health Information (PHI) as needed or required in order to process my insurance claims.
- I authorize CARTI to release the minimum necessary personal health information to any entity that assists in funding of any supportive services and/or financial assistance.

My signature indicates I have read and understand the above statements and consent to each:

_____ _____

Signature of Patient or Legal Representative (relationship to patient) **Date**