Chander PLLC
8970 W. Tropicana, Ste 6
Las Vegas, NV 89147

NEW PATIENT REGISTRATION FORM

Today's date:	Referring Physician /PCP :	How did you hear about us?

PATIENT INFORMATION

Patient Last:	First:	Middle:

Street Address:

City:	State:	Zipcode:

Home#:	Work#:	Ext:	Cell#:

Birthdate:	Sex:	SSN:	Email:	Drivers Lic#:

Marital Status:	Student Status:
❑Married ❑Single ❑Divorced ❑ Widowed ❑Legally Separated ❑Unknown	❑Not a student ❑Full-time student ❑Part-time student
Employed Status:	Residence Type:
❑Employed full-time ❑Employed part-time ❑Not employed ❑Self Employed ❑ Retired ❑On active military duty	❑Private Home ❑Nursing Home ❑Residential Treatment Patient ❑Skilled Nursing Home

Ethnicity:	Language:	Race:
❑Not Hispanic or Latino ❑ Hispanic or Latino	❑English ❑Spanish ❑Other	❑American Indian or Eskimo or Aleut ❑Asian or Native Hawaiian or Pacific Islander ❑Black or African American ❑White ❑Other Race

Insured Last:	First:	Middle:

Home#:	Work#:	Ext:	Cell#:

Birthdate:	Sex:	SSN:	Email:

Smart Heart Care 8970 W. Tropicana Ste 6 Las Vegas, NV 89147 Phone 702-473-5333 Fax 702-473-5444 Web: 4smartcare.com

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Primary Insurance:	Patient relation to the insured? ❑Self ❑Spouse ❑Child ❑Other	
Plan Name:	Group Number:	Member Id#:
Primary Insurance Address:		
City:	State:	Zip Code:
Secondary Insurance:	Patient relationship to the insured? ❑Self ❑Spouse ❑Child ❑Other	
Plan Name:	Group Number:	Member Id#:
Secondary Insurance Address:		
City:	State:	Zip Code:

Emergency Contact Last:	First:	Relationship:
Home Phone:	Email:	Permission to Speak To? ❑Yes ❑No

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and assign benefits to Chander PLLC dba Smart Heart Care/Smart Medical Care. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time of services are rendered. We cannot guarantee payment to Chander PLLC dba Smart Heart Care/Smart Medical Care. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Chander PLLC dba Smart Heart Care/Smart Medical Care. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over to outside collections, you will be responsible for all costs of the outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

Patient/Guardian signature	*Date*

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPPA

I____, understand that as a part of my health care, Chander PLLC dba Smart Heart Care/Smart Medical Care originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, 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 of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Chander PLLC dba Smart Heart Care/Smart Medical Care is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Chander PLLC dba Smart Heart Care/Smart Medical Care to disclose my protected healthcare information to the following person and/or people:

Name: ____ Relationship: _____________________________________

Name: ____ Relationship: _____________________________________

Name: ____ Relationship: _____________________________________

I fully understand and accept the terms of this consent.

X________________________________ __________________

Patient/Legal Guardian Signature Date

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