ARRHYTHMIA CENTER OF NORTHERN CALIFORNIA - WALTER KUSUMOTO, M.D., M.P.H.

REGISTRATION FORM

Patient Name: _____ Date Of Birth____/____/_____ Male Female
Last name First MI (Circle one)

Address_____
Street Apt City State Zip

Referred by/Cardiologist: _____ Social Security # _____--____--_____

Specialist/Primary Doctor _____ Home Phone # _____

Primary Care Doctor: _____ Work Phone # _____

Marital Status S M W D SEP **(circle one)** Cell Phone # _____

Preferred Contact Method: Home - Cell - Work **E-mail address_____**

Driver License #: _____ Race:_____ Ethnicity: _____
(ok to write "decline") **(ok to write "decline")**

Employer: _____ Employer Phone # _____

Name of person responsible for bill _____ ___Relationship to patient _____

Billing Address _____Billing Phone # _____
Street City State Zip

Responsible Party Driver License: _____ Responsible Party Social Security_____

Emergency Contact: _____ Relationship_____ Phone _____

Emergency Contact: _____ Relationship_____ Phone _____

Primary Insurance: _____ Subscriber # _____

Group # _____ Certificate # _____Policy # _____

If Spouse is the insured party, please provide their date of birth:_____

Secondary Insurance: _____ Subscriber # _____

Group # _____ Certificate # _____Policy # _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize WALTER T KUSUMOTO, MD and its doctors in charge of patient's care to perform all necessary and advisable medical procedures for diagnosis and treatment. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement, except in case of emergency. I also understand that I have the right to refuse any proposed medical procedure or treatment. I assign to and approve direct payment to WALTER T KUSUMOTO, MD of any insurance benefits otherwise payable for patient's treatment. However, I fully understand that I am financially responsible to WALTER T KUSUMOTO, MD for the charges not covered by this assignment. In the even it becomes necessary for WALTER T KUSUMOTO, MD to refer me to another facility or physician for additional tests, X-rays or medical care, I authorize them to release all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s),drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome(AIDS), or tests for or infection with human immunodeficiency virus(HIV).

MEDICARE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to WALTER T KUSUMOTO, MD for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient or supplier agrees to accept the charge determination of the Medicare carrier as the full-charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services.

Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

DATE_____ SIGNED_____