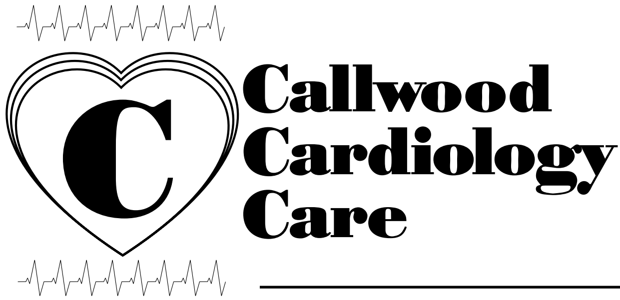


P.O. BOX 209 • 1236 Huffman Mill Road • Burlington, NC 27216 • (336) 538-1092

Welcome to Callwood Cardiology Care. As we aspire to provide you with the best care possible it is important that you are aware of our office polices. The following information is the help you learn and understand these policies.

When scheduling appointments, please be sure to identify any insurance coverage you have; this is to assist us in obtaining any necessary referral or pre-authorization required by your particular plan. If you were referred by another physician, we will do our best to obtain this information in advance to relive you of this concern.

For each visit, please remember to bring your insurance cards for us to copy. It is important that you bring a list of any medications you are currently taking (be sure to get the dosage prescribed) and any medications you are allergic to or unable to take. We also ask that you provide us with updated contact information (address and telephone number) as well as your primary physician's information.

Payment is expected and due at the time of service. This could mean your co-payment, 35% of the total fee, or a payment in full. As a courtesy, our insurance specialist will file insurance claims on your behalf as long as we have a copy of your insurance cards and a signed authorization form from you on file. Remember, the patient/guarantor is ultimately responsible for payment and insurance is considered a method of reimbursement for fees paid to the physicians; it is not a substitute for payment. Please ask to speak with our payments coordinator should your financial circumstances necessitate payment arrangements.

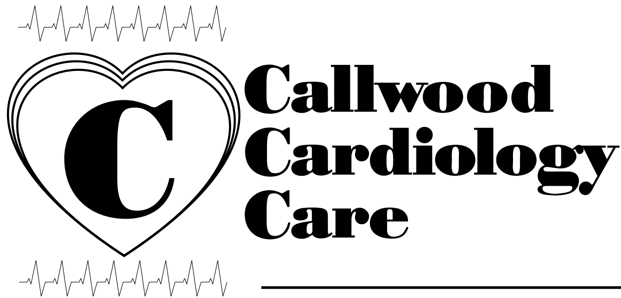
For prescriptions, please contact your pharmacy and have them fax refill requests to our office.
Our fax number is (336) 548-9696. Allow 72 hours for requests to be handled.

Thee is a charge of $25.00 for completion of forms brought into our office. This charge is due and payable at the time service is requested. This includes forms such as FMLA paperwork.

Please confirm your appointment in our office by phone within 24 hours of the scheduled date and time. If you fail to do so, we will require a $25.00 fee for each missed appointment.

We appreciate your cooperation and support of these policies. Again, thank you for choosing Callwood Cardiology for your medical care.

Dr. Dwayne D. Callwood, MD and the Medical Staff of Callwood Cardiology



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PRIVACY PRACTICES & YOUR INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways in which we use and disclose your health information for treatment, payment or any other health care operation purposes. You may also request that we limit our disclosures to persons assisting with your care or with payment for your care. While we will consider your request, we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that any information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Should we discover upon review that our information is accurate and complete, we many deny your request.

You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make, and uses and disclosures prior to April 14, 2003 among others. If you request this information from us more that once every twelve months, we may charge you a fee.

You have a right to receive a copy of this notice in written form. You may ask us for a copy at any time.

CALLWOOD CARDIOLOGY CARE, P.A.

Welcome to our practice. Please complete the following form so that we may keep your account information current. Thank you.

TODAY'S DATE: ______________________________

YOUR NAME: ____
IF OTHER THAN THE PATIENT

PATIENT'S NAME: ____
FIRST MIDDLE/MAIDEN LAST

DATE OF BIRTH: ______________ SEX: (M / F) SSN: _____________________________

ADDRESS: ____

CITY: _______________________________ ST: ______ ZIP: _____________________

HOME PHONE: _________________________ CELL PHONE: ____________________

EMAIL ADDRESS: ____

EMPLOYER: ____

WORK PHONE: ___________________________

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

SPOUSE/SIGNIFICANT OTHER'S NAME: _____________________________________

DATE OF BIRTH: ____________________ SSN: _________________________________

REFERRING PHYSICIAN'S NAME: ____

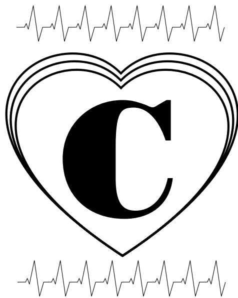
REFERRING PHYSICIAN'S PHONE/FAX: _____________________________________

****

PRIMARY INSURANCE NAME: ______________________________________

SECONDARY/OTHER INS. NAME: ____________________________________

Please bring your current insurance card(s) to each visit. Co-payments and/or co-insurance amounts are expected at the time of service.



Callwood Cardiology Care

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RELEASE OF MEDICAL INFORMATION

PATIENT NAME: ____
(PRINT)

Permission is hereby given to **Callwood Cardiology Care, P.A.** (Dr. Callwood and the staff members) to furnish any and all information that may be contained in my medical records to referring physicians and other medical entities as deemed necessary for continuity of care. I also authorize release of medical information to my insurance companies, disability insurance companies and my employer as necessary to process claims on my behalf. I will be responsible for any charges incurred from providing these records that are not paid by insurance or other entities.

It is understood that **Callwood Cardiology Care, P.A.** are *RELEASED* from *ALL LEGAL RESPONSIBILITIES* that may arise from releasing this information.

____
PATIENT SIGNATURE DATE

____
WITNESS SIGNATURE DATE

I have received a copy of the **Callwood Cardiology Care, P.A.** PRIVACY PRACTICES.

____
PATIENT SIGNATURE DATE