NSC Cardiology Inc – Dr Narendra Singh

2026 ANNUAL PATIENT PROFILE

PATIENT INFORMATION
Name:_____
Address:_____
_____
_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____

Gender at birth [ ] Male [ ] Female
Date of Birth: mm/dd/yyyy_____
Social Security #:_____
[ ] Married [ ] Single [ ] Widowed [ ] other
Spouse/Partner Name:_____
Referring Physician:_____
Family Physician:_____
Physician Phone #:_____
Do you have an Advance Directive ___ Yes ___ No

PATIENT EMPLOYMENT
[ ] Employed [ ] Retired [ ] Unemployed
Employer:_____
Phone:_____

PHARMACY INFORMATION

Pharmacy Name:_____
Pharmacy #:_____

GUARANTOR (Individual signing this form)
[ ] Same as Patient [ ] Other
Name:_____
Address:_____
_____
_____

GUARANTOR PHONE
Home #:_____
Cell #:_____

EMERGENCY CONTACT & PHONE #:
_____

PRIMARY INSURANCE
***Secondary Insurance: Please Provide Information to Front Desk**
Policy Holder's Name:_____
Policy Holder's Phone #:_____
Insurance Co:_____
Insurance Co Address:_____
_____

Relationship to Patient:_____
Policy Holder's SSN:_____
Insurance ID #:_____
Policy Group:_____
Policy Holder's DOB:_____

I consent to have messages regarding test results and appointment reminders left on a voicemail: (Initial)
_____Voicemail/Home #:_____
_____Voicemail/Cell #:_____
_____Voicemail/Business #:_____

I **do not** consent to have messages regarding my test results or appointment reminders on any voicemail:_____(Initial)

1. I voluntarily give consent for my medical treatment or my child's medical treatment to NSC Cardiology Inc**. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility.** When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

_____ _____
Signature Date

www.heartdrsingh.com or www.nsccardiology.com

NSC Cardiology Inc – Dr. Narendra Singh

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may review the current copy of the *Notice of Privacy Practices* on NSC Cardiology's website https://heartdrsingh.com/privacy-policy/.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list to whom we may release your medical records/information.

Name: _____Relationship: _____

Name: _____Relationship: _____

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been reviewed through this approval process. We may disclose medical information about you to people conducting a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave NSC Cardiology Inc., NSC Research Inc. We will almost always ask for your specific permission if the researcher will have access to your name or other information that reveals who you are, or actively be involved in your care at NSC Cardiology Inc., NSC Research, Inc.

ACKNOWLEDGEMENT FORM

I have reviewed the **Notice of Privacy Practices** (available at https://heartdrsingh.com/privacy-policy/or ask for a copy) and have been presented an opportunity to ask questions:

NAME: _____ Date of Birth: _____

Signature_____ Date: _____

NSC Cardiology Inc – Dr. Narendra Singh

FINANCIAL POLICY

We are all aware of the crisis to healthcare financing nationwide. Quality, personalized medical services may sometimes be expensive and we are working hard to contain costs on your behalf. There is much misunderstanding regarding the role of insurance and other "Third Party Payors" in the process. The following is an attempt to explain our policies in this regard:

1. Services are provided to patients, not to insurance companies. Private practice medicine is
. Fee-For-Service and implies a contract between patient and provider.
2. Insurance contracts are between companies and beneficiaries (patients) for reimbursement of certain covered expenses.
3. In cases where we do have contracts with managed care providers we will comply with their regulations. In other words, we will be filing your claims with the appropriate carriers and collecting your copay at the time of services. Please become familiar with your insurance requirements.
4. Patients covered under HMO or PPO are responsible for their copay at the time of service. They are also responsible for any portion of charges designated by the insurance company.
5. In order for our business office to file your insurance correctly, you must give the receptionist a copy of your most current insurance card along with your valid referral number at time of service.
6. If your HMO policy requires you to have a referral number, you are responsible to provide the valid referral number at time of services for each visit.
7. Patients electing to be seen out of network will be responsible for payment at time of services.
8. Patients covered under Medicaid must present current card and copay when applicable.
9. Recipients of medical care are expected to pay for those services whether covered by insurance or not. Insurance coverage is determined by your contract with the company.
10. If your insurance turns down a claim because it is not a covered service under your plan, or because it is a preexisting condition, etc., you are responsible for payment of these services.
11. If a Self-pay service is elected the service will not be filed through insurance companies.
12. For certain services (i.e., Procedures, Hospitalizations) we will assist you by filing a claim on your behalf to your insurance company. Bills not paid by insurance remain the responsibility of the patient.
13. In situations of severe financial hardship, this office will consider making special arrangements on a case-by-case basis. Please discuss this with our office manager immediately if you feel it applies to you.
14. We will mail / text you three statements once your insurance has settled your claim if you owe a balance. If you have not paid the balance or made payment arrangements, the account will be turned over to collections. In the event your account is sent to a collections agency for nonpayment you will be charged an additional $50 collections fee. Medical Device and Nuclear Medicine fees are subject to collections.
15. Any returned check written to our practice will incur a charge of $35. This will be added to your account for collections.
16. There is a $50 fee for missed appointments if we are not given at least a 24-hour notice. This fee is not covered by insurance and will be due prior to your next appointment being scheduled. Non payment will result in your account being turned over to a collections agency.
17. We are all here to serve. If you have remaining questions, our billing office and NSC Cardiology staff are ready to help find the answers.

I hereby understand the financial policy of this office.

_____

Print Name

_____ _____

Signature Date

www.heartdrsingh.com or www.nsccardiology.com

NSC Cardiology Inc - Dr. Narendra Singh

5400 Laurel Springs Parkway, Ste 1401 & 1402 Johns Creek, GA, 30024
1100 Northside Forsyth Dr, Ste 345, Cumming, GA, 30041
Phone - 678-208-0165 Fax -888-814-0852

REQUEST FOR RELEASE OF MEDICAL RECORDS

This form to be used if we need to get records from a previous physician or previous hospital stay

TO : _____

I hereby request that all my medical records be released to NSC Cardiology Inc promptly.

_____

Patient Name:_____ **Date:** _____

DOB:_____ **SSN:** _____

Address:_____

_____

Patient Signature:_____

Georgia law, (O.C.G.A. § 31-33-2(a)(2)), requires a physician to provide a current copy of the record to the patient under most circumstances. Also, O.C.G.A § 31-33-2(b) allows a patient or his/her designee to receive a copy of the requested record(s).

PLEASE FAX TO 888-814-0852

OR E-Mail to crystal@nsccardiology.com