Cardio Options, Inc.
CARDIAC MONITORING SPECIALIST

CARDIAC MONITOR ENROLLMENT FORM

OFFICE: (904) 268-6679
TOLL FREE: (800) 953-8460
FAX: **(904) 425-3236**

PATIENT TRANSMISSION LINE: TOLL FREE (877) 333-3466

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	SS #	
ADDRESS	CITY	STATE	ZIP
BIRTHDATE	EMAIL	GENDER M F	MARITAL STATUS Single Married Other
HOME PHONE #	WORK PHONE #	CELL #	EMERGENCY CONTACT#

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS YOUR INSURANCE CLAIM.
I request that payment of authorized medical benefits be made to me or on my behalf to Cardio Options, Inc. for any services furnished me by that provider. I authorize the release of any medical information necessary to process this claim. I will be responsible for loss or damage to the monitor and for the return of the equipment. I AGREE TO BE FINANCIALLY FOR ALL CHARGES. **I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**
PATIENT SIGNATURE_____DATE_____

INSURANCE INFORMATION

PRIMARY INS NAME	POLICY #	GROUP #	AUTHORIZATION #
SECONDARY INS NAME	POLICY #	GROUP #	AUTHORIZATION #

MONITORING INFORMATION

REASON FOR MONITORING	DX	PACEMAKER?	If yes, please specify:
ENROLLMENT START DATE	LENGTH OF STUDY:	SERIAL #	
MONITOR TYPE-CIRCLE ONE: (required) Telemetry / Event / *Other	Special Instructions: (*If "Other" was circled, please explain.)		

PHYSICIAN INFORMATION

CLINIC / PHYSICIAN NAME	PHONE #	FAX #	
ADDRESS	CITY	STATE	ZIP

INITIAL HERE: _____ Authorizes using an auto-trigger (AT) cardiac event monitor in place of the telemetry if patient does not meet enrollment criteria or is not approved by insurance.

PHYSICIAN'S SIGNATURE _____ Date _____
This signature states that I have examined the above patient and have determined that the test ordered above is medically necessary due to the patient's symptoms and/or medical condition.