Cardio Options, Inc.
CARDIAC MONITORING SPECIALIST

CARDIAC MONITORING 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:**	**MR NUMBER / SSN:**	
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
BIRTH DATE:	**HOME PHONE:**	**MOBILE PHONE:**	**GENDER:** M F
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 / ID #**	**GROUP #**	**AUTHORIZATION #**
SECONDARY INS NAME	**POLICY / ID #**	**GROUP #**	**AUTHORIZATION #**

MONITORING INFORMATION

MONITOR TYPE: (REQUIRED) ☐ **MOBILE CARDIAC TELEMETRY** *CONTINUOUS DATA ANALYSIS PLUS PATIENT ACTIVATED RECORDINGS AND AUTOTRIGGERED EVENTS. INCLUDES AF BURDEN.* ☐ **RX MINI PATCH** *CONTINUOUS DATA ANALYSIS PLUS PATIENT ACTIVATED RECORDINGS AND AUTOTRIGGERED EVENTS. INCLUDES AF BURDEN.* ☐ **OTHER:**_____	**MONITOR DURATION:** **3 7 14 21 30**	**SERIAL NUMBER:**	**PACEMAKER:** YES NO
	REASON FOR MONITORING		
☐ **EVENT** *PATIENT ACTIVATED / AUTOTRIGGERED WIRELESS COMMUNICATION*	**SPECIAL INSTRUCTIONS:**		

PHYSICIAN INFORMATION

CLINIC NAME:	**ORDERING PHYSICIAN:**	**CONTACT NUMBER:**
ADDRESS:	**CITY:**	**FAX NUMBER:**

INITIAL HERE: _____ Authorizes using an auto-trigger (AT) cardiac event monitor in place of the mobile cardiac 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.