Pocket Angiogram®

PHYSICIAN ENROLLMENT FORM

ACCOUNT INFORMATION

Date

Name of Organization____

Address______________________ City______________ State________ Zip Code __________

Phone Number (____) ________--__________ Fax Number (____) ________--__________

Internet Address ________________________ E-mail Address ________________________

Type of Patient Software Database:______________ Manufacturer:______________________

Type of Medical practice: ☐ Cardiology ☐ Cardiovascular Surgery ☐ Other (List) ______________

Administrator Name ______________ Phone (____) ________--__________ E-mail ______________

Name of Physician leader in group______________________ E-mail ______________

Number of patients in practice______________Number of new patients per week______________

Number of Physicians in group__________ Angiograms per month __________ CABGs per month__________

Names of Physicians participating in the Pocket Angiogram Program and their corresponding Assistants:

(Add additional Physicians on separate page if needed)

Physician Name	Assistant Name
1. ______________	______________
2. ______________	______________
3. ______________	______________
4. ______________	______________
5. ______________	______________
6. ______________	______________

POCKET ANGIOGRAM PROGRAM COORDINATOR

Name______________________________ Title______________________

Phone (______) __________--______________ Fax (______) __________--______________

Best time to contact: ______________________ E-mail ______________________

Estimated Number of Pocket Angiograms per week ______________

BILLING CONTACT

Name ______________________________Position______________________

Address______________________ City______________ State_____ Zip Code______________

Phone Number (______) _______--__________ Fax Number (______) _______--__________

Email ______________________

POCKET ANGIOGRAM REIMBURSEMENT POLICY

☐ Patient absorb cost ☐ Funding from Industry (List) ______________

☐ Physician absorb cost ☐ CPT code (List) ______________

☐ Patient and Physician share cost ☐ Other (List) ______________

ENROLLMENT AND CARD DESIGN (SEE CARD OPTIONS SHEET)

1. Indicate the Pocket Angiogram program that you are enrolling in: (check all that apply)

   ☐ Pocket Angiogram Card Service only ☐ Pocket Angiogram Card with Patient Satisfaction Survey or

   ☐ Pocket Angiogram Card with Referring Physician Summary Report.

2. Select the Pocket Angiogram Card design (your logo location and color)

   ☐ Black and White Logo (bottom) ☐ Black and White Logo (top) ☐ Color Logo (bottom) ☐ Color Logo (top)

3. Attach a copy of your logo and font type that is to be placed on the Pocket Angiogram Card (you may use letterhead or camera ready art work)

4. Enter enrollment fee amount $__________

   Mail enrollment form, logo design and payment to:

   CARDIOMARK LLC
   P.O. BOX 929
   SAN LUIS OBISPO, CALIFORNIA 93406

Any questions please contact us at: *1.800.589.4949, FAX 805.927.9378* or visit www.cardiomarkllc.com

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