Heart Consultants, LLC

REGISTRATION/CONSENT FORM

(PLEASE PRINT)

DATE:_____	**PCP:**_____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:	□MR. □MRS. □MISS □MS	MARITAL STATUS: □ SINGLE □ MARRIED □ DIV □ SEP □ WID
_____	_____ _	_____ _		

DATE OF BIRTH _____/_____/_____	AGE: _____	SEX: □M □F	IS THIS YOUR LEGAL NAME? □SI □NO	IF NOT, WHAT IS YOUR LEGAL NAME? _____	(FORMER NAME) _____

SOCIAL SECURITY: _____-____-_____	HOME #: (_____)-_____ -_____	CELL#: (____)-____-_____

STREET ADDRESS:	P.O BOX:	CITY:	STATE:	ZIP CODE:
_____	_____	_____	_____	_____

OCCUPATION:_____	EMPLOYER:_____	EMPLOYER PHONE NUMBER: (____)-____-_____

CHOSE CLINIC BECAUSE/ REFERRED TO CLINIC BY (PLEASE CHECK ONE BOX)	❑ Dr. _____	❑ Insurance Plan _____	❑ Hospital _____

❑ Family	❑ Friends	❑ close to my house/ job	❑ yellow pages	❑ Other

Other family members seen here?

Primary Care Physician:	Phone Number: (_____)-____ -_____
Referring Physician:	Phone Number: (_____)-____ -_____
Pharmacy:	Phone Number: (_____)-____ -_____
Spouse's Last Name: First Name:	Phone Number: (_____)-____ -_____
SOCIAL SECURITY: _____-____-_____	Phone Number: (_____)-____ -_____
Employer:	Phone Number: (_____)-____ -_____

INSURANCE INFORMATION

Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.

Person responsible for bill: _____	Date of birth: ____/____/____	Address (if different) _____	Phone Number: (____)-____ -_____

Is this person a patient here? ❑ YES ❑ NO

Occupation: _____	Employer: _____	Employer Adderss: _____	Phone number: (_____)-_____ -_____

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate Primary Insurance: _____

Subscriber's Name: _____	Subscriber's S.S.#: ____-____-____	DOB: ____/____/____	Group Number: #_____	Policy Number: #_____	Co-pay: _____

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other_____

Name of secondary insurance (if applicable): _____	Subscriber's S.S.#: ____-____-____	Group Number: #_____	Policy Number: #_____

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)_____	Relationship to patient: _____	Phone number: (_____)-_____ -_____	Work Number.: (_____)-_____ -_____

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS
A PATIENT OF **HEART CONSULTANTS**, ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HERBY AUTHORIZE **HEART CONSULTANTS**, TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO **HEART CONSULTANTS** ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE PROVIDER AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT: I UNDERSTAND THAT **HEART CONSULTANTS**. MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES **HEART CONSULTANTS** TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW **HEART CONSULTANTS** PRIVACY NOTICE, TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE. I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, **HEART CONSULTANTS** MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT **HEART CONSULTANTS** MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO **HEART CONSULTANTS**.

HIPPA ACKNOWLEDGEMENT: I HAVE RECEIVED AND HAVE READ **HEART CONSULTANTS** NOTICE OF PRICACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

_____.

(PLEASE LIST AUTHORIZED REPRESENTATIVE (S) OR MARK N/A)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

_____

PATIENT/GUARDIAN SIGNATURE DATE