



Heart Consultants, LLC

REGISTRATION/CONSENT FORM (PLEASE PRINT)

| | |
|-------------|------------|
| DATE: _____ | PCP: _____ |
|-------------|------------|

PATIENT INFORMATION

| | | | | |
|---------------------|----------------------|-----------------------|--|---|
| LAST NAME: _____ | FIRST NAME: _____ | MIDDLE NAME: _____ | <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS <input type="checkbox"/> MS | MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIV <input type="checkbox"/> SEP <input type="checkbox"/> WID |
|---------------------|----------------------|-----------------------|--|---|

| | | | | | |
|---------------------------------|---------------|--|---|---|------------------------|
| DATE OF BIRTH ____/____/____ | AGE: _____ | SEX: <input type="checkbox"/> M <input type="checkbox"/> F | IS THIS YOUR LEGAL NAME? <input type="checkbox"/> SI <input type="checkbox"/> 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: (____) - ____ - ____ |
|-------------------|-----------------|---|

| | | |
|---|---|-----------------------------------|
| CHOOSE CLINIC BECAUSE/ REFERRED TO CLINIC BY (PLEASE CHECK ONE BOX) | | |
| <input type="checkbox"/> Dr. | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Hospital |

| | | | | |
|---------------------------------|----------------------------------|---|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Family | <input type="checkbox"/> Friends | <input type="checkbox"/> close to my house/ job | <input type="checkbox"/> yellow pages | <input type="checkbox"/> 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 Address: _____ | 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: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other _____ |
|---------------------------------------|-------------------------------|---------------------------------|--------------------------------|--------------------------------------|

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

| | | | | |
|---------------------------------------|-------------------------------|---------------------------------|--------------------------------|--------------------------------------|
| Patient's relationship to subscriber: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> 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 CONCERNING 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