Date ______________________

How did you hear about HeartPlace?

- ☐ Physician Referral ☐ Advertisement
- ☐ Friend ☐ Other Please Specify ______________

For Office Use Only
Verified Date ______________
By: ______________
System Account # ______________
Date/By: ______________

Patient Information

Name ______________ (last, first, middle) Doctor ______________

Social Security # ______________ Email Address: ______________

Address ______________ City ______________ State ____ Zip ______

Home Ph. (____) ______________ Business Ph. (____) ______________ Cell Ph. (____) ______________

☐ Married ☐ Single ☐ Widow ☐ Divorced Age ______ Date of Birth ______________ ☐ Male ☐ Female

Employer Name ______________ Employer Address ______________

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self-Employed ☐ Student - Fulltime ☐ Student - Parttime

Referring Physician ______________ Referring Physician Ph. (____) ______________

Primary Care Physician ______________ Primary Care Physician Ph. (____) ______________

Insured Name (If no insurance, responsible party)

Name ______________ Relationship ______________

Social Security # ______________ Date of Birth ______________

Address ______________ City ______________ State ____ Zip ______

Home Ph. (____) ______________ Business Ph. (____) ______________ Cell Ph. (____) ______________

Employer Name ______________ Employer Address ______________

Notify In Case of Emergency

1. Name ______________ Relationship ______________ Home Ph. (___) ______________ Business Ph. (___) ______________
2. Name ______________ Relationship ______________ Home Ph. (___) ______________ Business Ph. (___) ______________

Insurance Information - Copies of Insurance Cards and Drivers License are Required

Insurance 1 ______________

Address ______________ Phone (___) ______________

SS# ______________ Policy # ______________ Group # ______________

Insurance 2 ______________

Address ______________ Phone (___) ______________

SS# ______________ Policy # ______________ Group # ______________

Authorizations

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the reciept of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed ______________ Date ______________

Patient Name (Please Print) ______________

Witness Signature ______________ Date ______________