

For Office Use Only
Verified Date: _____
By: _____
System Account#: _____



How did you hear about HeartPlace?

Physician Referral Advertisement
 Friend Other: _____ Date: _____

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 Full-Time Student Part-Time
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: _____ Ph.#: _____ Wk.#: _____
2. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

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

Insurance 1: _____
Address: _____ Ph.#: (____) _____
SS#: _____ Policy #: _____ Group #: _____
Insurance 2: _____
Address: _____ Ph.#: (____) _____
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 receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Patient Signature: _____ Date: _____
Patient Name (Please Print): _____
Witness Signature: _____ Date: _____