Heart Clinic of Louisiana

PATIENT REGISTRATION FORM

Account #: _____

Name: _____
(First) (M) (Last)

Address: _____
(Street) (Apt. #)

_____
(City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Social Security #: _____ Sex: M F

Email Address: _____

Patient's Employer: _____ Office Phone: _____

Patient's Occupation: _____

Emergency Contact: _____ Phone: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____ Office Phone: _____

Responsible Party: _____

Today's Dr.: _____ Referring Dr.: _____

Family Dr.: _____

How did you hear about our office: ❑ Relative or Friend ❑ Family Doctor
❑ Other _____

To The Responsible Party:

It is the policy of the Heart Clinic of Louisiana to collect all copayments and cost shares at the time services are rendered. If you have medical insurance we will be happy to assist you in filing on your behalf. However, you will be responsible for the entire bill, if it is not paid by your insurance carrier. In the event your account is turned over to an attorney for collection, you will be charged for all attorney fees.

I hereby request and authorize my insurance company and/or companies to pay Heart Clinic of Louisiana directly any proceeds payable under the terms of my policy and/or policies. This is an irrevocable assignment and I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid by me.

I hereby consent to Heart Clinic of Louisiana release of medical information about me to carry out treatment, payment, or health care operations.

Date: _____ Signed: _____

(over)

Acknowledgement of Notice of Privacy Practices

I have been provided with and read a copy of Heart Clinic of Louisiana's Notice of Privacy Practices.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

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Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff to: Disclose the following protected health information: General Medical Information to person (s) listed below. List name and relationship of who you wish to allow access - for example, your spouse, sibling, neighbor, caretaker. Additional space on Addendum.

Name Relationship

Name Relationship

Name Relationship

Name Relationship

The protected health information is being used or disclosed for the following purposes: At the request of the individual signing this form.

This authorization shall be in force and effect until this authorization is revoked in writing at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Heart Clinic of Louisiana. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except:

(1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority