Atlanta Heart Associates, P.C.

CONFIDENTIAL PATIENT INFORMATION SHEET

PLEASE PRESENT A PHOTO ID AND ALL INSURANCE CARDS AT THE FRONT DESK

PLEASE PRINT LEGIBLY

Salutation _____ Full Name _____Suffix _____

Date of Birth _____ Sex ☐ Male ☐ Female Marital Status _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Primary Contact Number _____ Secondary Contact Number _____

Social Security Number _____

Email Address _____

Primary Care Physician/Phone _____

Emergency Contact: Please list this person on your **Personal HIPAA Form** to follow or we will not be authorized to be speak with this person. The contact phone number must be different than the patient's.

Name _____ Phone _____

Please tell us how you heard about us. Circle any that apply.

Print Ad Internet Search Our Website Facebook/Social Media Friends/Family

Doctor Referral Former Patient Saw Our Doctor in the Hospital Other _____

Government Required Information

Please circle one: Hispanic or Non-Hispanic Race _____

Primary Language Spoken _____ Other Language _____

We require all patients to show their insurance or managed care membership card and their driver's license so that we may make copies for our permanent record.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient so he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemization to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AND RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize Atlanta Heart Associates, PC, to treat me and to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and/or attorney fees associated with my failure to pay my debt. A facsimile of this authorization will be as valid as the original.

I understand that if I fail to keep a scheduled appointment that I will be responsible for a no show fee.

I hereby authorize Atlanta Heart Associates, PC to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.

Signature of Patient (Guardian)_____Date _____

Patient Name _____ DOB _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Number _____ Group Number _____

Policy Holder Name (if different than patient) _____

Relationship _____ Social Security # _____ DOB _____

Secondary Insurance _____

Policy Number _____ Group Number _____

Policy Holder Name (if different than patient) _____

Relationship _____ Social Security # _____ DOB _____

HIPAA - CLINICAL

Please list any doctors that you currently see.

Name _____ Specialty _____

City _____Phone _____

Name _____ Specialty _____

City _____Phone _____

Name _____ Specialty _____

City _____Phone _____

HIPAA – PERSONAL

Please list any persons that Atlanta Heart Associates, P.C. is allowed to discuss your protected health information with. This includes, but is not limited to your treatment, health care options, test results, appointment reminders, and medical bills. Please include your Emergency Contact listed on the first page.

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

By signing this authorization, I authorize Atlanta Heart Associates, P.C. to use and/or disclose protected health information (PHI) about me to the parties listed above. I understand that I can revoke or amend this authorization at any time.

Signature of Patient (Guardian)_____Date _____