The Heartbeat Clinic

Amer Suleman M.D

PCP:	Phone:	Referring:	Phone:

PATIENT INFORMATION

Patient's last name:	First:	MI	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms. ❑ Sir	Marital status (circle one) Single / Married / Divorced Separated / Widowed / Other	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M ❑ F	
Street address:		Home phone no.:		Cell phone no.:		
City:	State:	ZIP Code:	Social Security Number:			
Email:	Employer and Occupation:		Employer phone no.:			
Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance cards and drivers license to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no. (if different):
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.:
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Blue Cross	❑ Cigna	❑ Humana
❑ Aetna	❑ United Health Care	❑ Tricare	❑ Secure Horizon	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Heartbeat Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Policies & Consents

Please read and review carefully, then sign and date.

Financial Policy: As a courtesy to you, The Heartbeat Clinic will file all insurance claims for you. **It is your responsibility to present us with your most current insurance card and information.** Failure to do so may cause you to be responsible for the entire bill. Failure to inform us of these changes may cause your insurance company to deny payment.

Appointment Cancellations: There is a $25.00 fee added to all accounts for any appointments that are cancelled, missed or broken without a 24-hour notice. If the office is closed please leave a message with our answering service and we will return your call the next business day. If you do have any questions concerning this matter please let us know.

Form Fee: There is a $15 fee for processing forms which require more than physician signature. Some forms may have a higher fee. This is billable directly to you (not your insurance company) and should be paid prior to the completion of the forms.

Privacy Policy: You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practice carefully. It provides more detail on how The Heartbeat Clinic may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested from The Heartbeat Clinic.

If you would like to request a restriction, please do so in writing. However, The Heartbeat Clinic reserves the right to deny your request. If granted a request, we are bound by the terms of this agreement. You may also revoke this consent in writing. However, information on any treatment or service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care options. Refer to the Notice of Privacy Practice for further information.

Disclosure & Consent for Testing: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing all the ricks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may consent to the procedure is you so desire. Additionally, understand that these procedures may be compared to past or further procedures to help discover any changes in your condition that may occur.

Every effort will be made to minimize the risks and the procedures will be monitored continually. The risk of death as a result of the planned procedure is approximately 1 in 10,000, which is less than the risk of death in any 24-hour period for a given person who undergoes such procedures.

I understand that the procedure will be stopped at my request, the physician's decision that it should be stopped, or upon the completion thereof. I have been given the opportunity to ask questions about the procedure and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I have read, understand and agree to all of the policies and consents listed above.

Patient Name: _____ Date of Birth: _____

_____

Patient Signature / Responsible Party

Date_____

_____

Witness Signature

The Heartbeat Clinic

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REQUEST FOR RELEASE
OF PATIENT HEALTH CARE INFORMATION

Patient Name: _____ DOB: _____

I herby request The Heartbeat Clinic to be **ABLE** to release any health care information in my medical record to:

1. Full Name_____

   Relationship: _____ Contact Number: _____

2. Full Name: _____

   Relationship: _____ Contact Number: _____

3. Full Name: _____

   Relationship: _____ Contact Number: _____

I herby request The Heartbeat Clinic to **RESTRICT** the release of any health care information in my medical record to:

☐ Please check this box if you wish **NOT** to have any health care information released at this time.

1. Full Name: _____

   Relationship: _____ Contact Number: _____

2. Full Name: _____

   Relationship: _____ Contact Number: _____

In the event I am called, but not available, I herby give the right for The Heartbeat Clinic to

☐ Leave a detailed voice message. Best number to be reached is _____

☐ Leave only a general voicemail

I understand that I have a right to terminate this request either verbally or in writing at any time. I also understand that this practice has the right to decline my request to release or restrict the disclosure of my protect health information.

Patient Signature: _____ Date: _____