The Heartbeat Clinic

Amer Suleman M.D

PCP:				Referring:		
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* «encDate»

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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, if your failure to inform us of these changes causes your insurance company to deny payment. ***REMINDER: Check your individual benefit coverage!*** It is our policy to pre-authorize/notify your insurance company for all sleep studies, long term telemetry monitors, hospital procedures, video EEG, and nuclear studies. But pre-authorization/notification does not guarantee payment of benefits by your insurance company. It is your responsibility to check your benefits in your benefit booklet or by contacting your insurance company. All non-covered benefits for sleep studies, long term telemetry monitors, video EEG, nuclear studies, and hospital procedures will be the patient/members responsibility.

Appointment Cancellations: There is a $75.00 fee added to all accounts for any appointments that are cancelled, missed, or broken without 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. You can also send a portal message or email us at info@thbc.us. 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 a 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.

Medical Records Request: At any time, you may request a copy of your records or request them to be sent to another facility. We will request that we have a release of information form on file to process your request. This form is on our website (thbc.us). You can fill it out electronically under patient forms or print the PDF and send it in to us by email at info@thbc.us or fax it to (214) 504-9940. We charge $27.10 for all records requests. This is for the fee to process the request (including supplies and time). Payment will be required up front for request by mail otherwise records are provided electronically through our third-party company (Vital Records Control). If at any time you need to check the status on records request, you can contact Vital Records Control at (972) 399-0914 or our office at (214) 504-9942 ext 252.

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 to undergo the procedure after knowing all the 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 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 because 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.

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Patient Portal: We are pleased to announce that we now have a patient portal available. Patients can enter medical history on-line, send messages to their doctor's office, refill prescriptions, schedule appointments, receive reminder notices from the office and view patient consent forms. To be signed up for the services please add your email address here: _____. We will then provide you with a username and password.

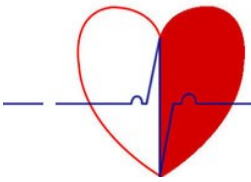
Telemedicine Informed Consent: Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my healthcare provider present in the room. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. a. I may revoke my rights at any time by contacting The Heartbeat Clinic at 214-504- 9942. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. a. I understand that my insurance carrier will have access to my medical records for quality review/audit. b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits. I understand that this document will become a part of my medical record. By signing this form, I attest that I have personally read this form (or had it explained to me) and fully understand and agree to its contents; have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; I am located in the state of Texas and/or will be in Texas during my telemedicine visit(s).

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

Patient Name: _____ Date of Birth: _____

_____ _____ _____

Patient Signature / Responsible Party Date Witness Signature



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REQUEST FOR RELEASE
OF PATIETN HEALTH CARE INFORMATION

Patient Name: _____ DOB: _____

I hereby 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.
- ☐ Send a portal message.
- ☐ Send an email to _____
- ☐ Send a text message to _____

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 protected health information.

Patient Signature: _____ Date: _____ Witness Signature: _____