FLORIDA HEART CLINIC

CHRISTIAN M. HEESCH, MD

PATIENT INFORMATION

NAME ______________________________ ________________________________ **BIRTH DATE** ______________________ **AGE** _______

ADDRESS ____

CITY _________________________________ **STATE** _______ **ZIP CODE** ___________ **CELL PHONE #** ____________________________________

E-MAIL ADDRESS: ____

Referred to our clinic by (please check one box): □ Dr. ____

□ Insurance Plan □ Hospital □ Family □ Friend □ Close to home/work □ Yellow Pages □ Internet □ Other______

PRIMARY CARE PHYSICIAN'S NAME ______________________________________ **PHONE #** ____

PHARMACY NAME & ZIP CODE____ **PHONE #** ____

MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

SPOUSE'S NAME ____ **PHONE #** ____

EMERGENCY CONTACT NAME ____ **PHONE #** ____

RELATIONSHIP TO YOU ____

INSURANCE INFORMATION

PRIMARY INSURANCE ____ **MEMBER ID** _____________________________________

INSURED'S NAME ____ **DATE OF BIRTH** ___________________________________

YOUR RELATIONSHIP TO INSURED ___________________________

SECONDARY INSURANCE (IF ANY) _____________________________________ **MEMBER ID** _____________________________________

INSURED'S NAME ____ **DATE OF BIRTH** ___________________________________

YOUR RELATIONSHIP TO INSURED ___________________________

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party pay or, for services rendered by the physician and I also authorize the release of any medical information necessary to process this claim.

____ ____

Signature Date

TERMS OF PAYMENT

Payments of all co-pays, deductibles, and/or coinsurance are due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. For your convenience, we accept credit cards including Visa, MasterCard, Discover and Debit Cards.

Due to the constant changes in health insurance it is **your responsibility** to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you.

FEES AND INSURANCE INFORMATION / PHYSICIAN'S RELEASE AND ASSIGNMENT

I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I fully understand that I am directly responsible for the payment to the Physician's office for all medical services rendered to me. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. If insurance claims are filed by this office on my behalf, I permit a copy of the authorization to be used in place of the original.

Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Due to multiple problems with billing and collections, effective immediately, you will be responsible for your total bill after two-month period from the time that it was filled, if your insurance company has not reimbursed us.

REFERRAL / CANCELLATION POLICY

Thank you for choosing us as your health care provider. Our staff and physician are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

We ask 24-48 hours to process prescription requests and prescription refills.

If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you are aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit.

Should you arrive late to your appointment, you may be asked to reschedule, or you may have to wait to be seen between or after other patients who have arrived on time.

Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $25.00. Please help us better serve you better by keeping your scheduled appointments.

______________________________	______________________	________________
Patient Name (Please Print)	Patient Signature	Date

FLORIDA HEART CLINIC

CHRISTIAN M. HEESCH, MD

RELEASE OF MEDICAL RECORDS

This consent form allows Florida Heart Clinic, LLC to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Florida Heart Clinic, LLC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Florida Heart Clinic.

_____ I hereby authorize that Florida Heart Clinic, LLC may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Florida Heart Clinic, LLC may disclose my personal health information to the person who I have listed as my emergency contact.

_____ I hereby authorize that Florida Heart Clinic, LLC may disclose my personal health information to the Initial following person(s):

	Name	Telephone number	Relationship to Patient
1.			
2.			
3.			

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Florida Heart Clinic, LLC services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Florida Heart Clinic, LLC may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while Florida Heart Clinic, LLC is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.
I understand that Florida Heart Clinic, LLC may refuse me services if I refuse to sign this consent.

ACKNOWLEDGEMENT FORM
1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

______________________________ ______________________________ ______________________________

Patient Name (Please Print) Patient Signature Date

FLORIDA HEART CLINIC

CHRISTIAN M. HEESCH, MD

3. USE AND DISCLOSURE OR YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you
FOR PAYMENT: We may use and disclose your medical information for payment purposes.
FOR HEALTH CARE OPERATIONS: we may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of Employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
FOR LAW ENFORCEMENT: we may use and disclose your medical information for purposes as defined by federal and state law.
I have read the Notice of Privacy Practices and I have been provided an opportunity to review it.

____ _____________________________ _____________________

Patient Name (Please Print) Patient Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).
The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):
Home Telephone: ___________________________________

- o Okay to leave message with detailed information
- o Leave message with call-back number only

Work Telephone: _____________________________________

- o Okay to leave message with detailed information
- o Leave message with call-back number only

Written communication

- o Okay to mail to my home address
- o Okay to mail to my work/office address
- o Okay to fax to this number _____________________

Other ____

___________________________________ _____________________________

Patient Signature Date

____ _____________________________

Print name Birthdate