



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

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone _____ Daytime Phone _____ Mobile Phone _____

Social Security Number _____ Marital Status _____

Email Address _____

Primary Care Physician: _____

Primary Care Physician Phone _____ City _____

Government Required Information

Please Circle One: Hispanic or Non-Hispanic

Race _____

Primary Language Spoken _____ Other

Language _____

Emergency Contact: Please list this person on your Personal HIPPA Form to follow or we will not be authorized to speak to this person.

Name _____ Phone _____

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 patients 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 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 # _____ Date of Birth _____

Secondary Insurance _____

Policy Number _____ Group Number _____

Policy Holder Name (if different than patient) _____

Relationship _____ Social Security # _____ Date of Birth _____

Third Insurance _____

Policy Number _____ Group Number _____

Policy Holder Name (if different than patient) _____

Relationship _____ Social Security # _____ Date of Birth _____

Please sign the attached assignment of benefits granting us permission to file claims with your insurance company.

It is your responsibility to notify Atlanta Heart Associates, P.C. of any changes to your insurance coverage.

Patient Name _____ DOB _____

HIPPA – CLINICAL

Please list any doctors that you currently see.

Name _____ Specialty _____

City _____ Phone _____

Name _____ Specialty _____

City _____ Phone _____

Name _____ Specialty _____

City _____ Phone _____

Name _____ Specialty _____

City _____ Phone _____

Name _____ Specialty _____

City _____ Phone _____

PHARMACY INFORMATION

Local Pharmacy Name _____ Phone Number _____

Address _____

Mail Order Pharmacy Name _____ Phone Number _____

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

Signature _____ Date _____

Patient Name _____ DOB _____

HIPPA – PERSONAL

Please list any persons that Atlanta Heart Associates, PC 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.

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

By signing this authorization, I authorize Atlanta Heart Associates, PC to use and/or disclose protected health information (PHI) about me to the parties listed above. I understand that I will be required to update this information on a yearly basis. I understand that I can revoke or amend this authorization at any time.

Signature _____ Date _____

Please also sign the attached sheet acknowledging that you have been provided a copy of our privacy practices.

I have read and understand Atlanta Heart Associates, PC office policies and I agree to abide by the same.

Signature _____ Date _____

EXTRA COPIES OF OFFICES POLICIES AND PRIVACY PRACTICES
ARE AVAILABLE AT THE FRONT DESK