SIGNET HEART GROUP

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single / Mar / Div / Sep / Wid

Ethnicity : ❑ Declined ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Race : ❑ Declined ❑ American Indian ❑ Asian ❑ White ❑ Black or African American ❑ Native Hawaiian	Social Security #:	Date of Birth: / /	Age:	Sex: ❑ M ❑ F

Primary Language : _____	Primary Care Physician /Referring Doctor's Name: _____
Mailing Address:	PRIMARY Phone # ( ) / Secondary Phone # ( )

City:	State:	Zip Code:	Email Address:
Occupation:	Employer:		Work Phone # ( )

Preferred Pharmacy (Please include name & address):

❑ Local Pharmacy: _____

❑ Mail Order Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance Carrier	*Group Number:*	*Birth Date:*
Member ID #	*Who is the insured?*	*Relationship to the Insured*
Secondary Insurance Carrier:	*Group Number*	*Birth Date:*
Member ID #	*Group Number*	*Birth Date:*

GUARANTOR / RESPONSIBLE PARTY		

IN CASE OF EMERGENCY		
Name of friend or relative:	Relationship to patient:	Home Phone: Cell Phone:

This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ***Signet Heart Group*** *or insurance company to release any information required to process my claims.*

Patient/Guardian Signature: **Date:**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Address: _____

Date of Birth:_____ Social Security Number: _____

Authorizes Signet Heart Group to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip_____ Phone Number: _____

□ Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? □ Yes □ No

May we contact you at home and/or leave a message regarding appointments? □ Yes □ No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid. □ Yes □ No

_____ _____

Signature of Patient or Representative Relationship to Patient

_____ _____

Date Signed Witness Signature

Office Policies

Patient Name: _____ **Date of birth:** _____

As a patient of Signet Heart Group I understand that the following policies are currently in effect:

- A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.

- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.

- **I am to present proof of my insurance coverage at *every* office visit**.

- **NO SHOWS**- If you do not show up to 3 or more consecutive appointments, we will **NOT** schedule anymore appointments and you will be dismissed from our practice.

- **NO SHOWS-** No Show for a PET Scan appt- there will be a $200 fee.
  No Show for a Nuclear Stress Test- there will be a $100 fee.
  No Show for an Echo/Vascular Test- there will be a $50 fee.

- **Finally, I understand that I am to allow at least 48 hours for my prescription refills**.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

_____ _____

Patient Signature **Date**

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Signet Heart Group to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Signet Heart Group

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that SHG reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that SHG is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

Relationship to Patient