☐ INSURANCE CARDS COPIED MR #:________________________

PATIENT REGISTRATION

PATIENT

First Name:____Middle Initial:_______Last Name:____

Date of Birth:____ Sex: ☐ Male ☐ Female Social Security #:____

Mailing Address:____

City:____State:______________Zip Code:____________________________

Home Phone #:____Cell Phone #:____

MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D ☐ SEP

EMPLOYMENT STATUS: ☐ FT ☐ PT ☐ RET ☐ DISABLED

Employer's Name:____

Employer's Address:____City:__________________________________ State:______________ Zip Code:___________

Work Phone #:____

Physician seeing today: ____ Referring Physician:_____________________________________

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EMERGENCY INFORMATION

Name:____Phone #:____

Relationship:____

Mailing Address:____

City:____State:______________Zip Code:____________________________

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INSURANCE INFORMATION: (Please provide receptionist copies of your insurance cards)

Primary Insurance:____ID#:__________________________________Group #:______________________________

Guarantor:____

Guarantor's DOB:____Guarantor's SS#:____

Secondary Insurance:____ID#:__________________________________Group#:______________________________

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CLINIC POLICY, CONSENT FOR TREATMENT & INSURANCE

I, the undersigned, authorize the provider of services of HeartSouth, PLLC, and its designees to provide treatment and services, and may use my health information for treatment, payment and health care operations, which includes submitting information to Medicare, Medicaid, and/or other third party payors for the purposes of processing insurance claims. I further authorize non-practice labs, radiology centers, pathologists and radiologists who may interpret and/or report on diagnostic tests ordered by HeartSouth, PLLC to provide such treatment and use my health information for billing and payment purposes. I understand that I am responsible for payment of services rendered to me by HeartSouth, PLLC. For all children under eighteen (18) years of age, the parent or guardian requesting treatment assumes all financial responsibility. Payment is due at the time of service including any co-payment and deductibles.

If my account were to require the services of a collection agency, I understand that I will be responsible for all fees related to the collection process including collection agency fees and attorney's fees.

Signature:____ Date:____

I, the undersigned, assign directly to HeartSouth, PLLC, all medical benefits payable on my behalf for services rendered to me by HeartSouth, PLLC providers. I authorize HeartSouth, PLLC to release all information necessary to secure payment of benefits. I authorize the use of this signature for insurance billing purposes.

Signature:____* Lifetime Signature Date:____

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Revised 6/17/09