PATIENT INFORMATION

Patient First Name: _____ Last name: _____ DOB:_____

SSN#_____Primary Phone:_____ Okay to leave voicemail? ☐ Yes ☐ No

Street Address_____Apt#_____ City_____State/Zip_____

Sex: (circle one) M F Marital Status: (circle one) S M D W Primary language:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other:_____

Race: ☐White/Caucasian ☐Black/African American ☐Asian ☐ Other:_____

Email: _____

(You will receive an invitation to create an account in our patient portal, available 24 hours, to obtain your medical records or make changes)

Primary Care Physician:_____ Phone:(_____)_____

Pharmacy Name:_____ Phone:(_____)_____

Pharmacy Address:_____

Primary Insurance Provider Information

Primary Insurance Company _____

Policy Number _____ Group Number_____

Secondary Insurance Provider Information

Secondary Insurance Company_____

Policy Number_____Group Number_____

_____

Patient or Legal Representative Name (PRINT)

_____ _____

Patient or Legal Representative Signature Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This *Authorization for Disclosure of Protected Health Information* confirms you have read and agree to *Notice of Privacy Practices* that is available patient review in the office and a personal copy can be provided upon request.

Your signature authorizes Heart Rhythm Solutions to receive, send, and disclose protect health information to the medical providers and/or individuals specified below. Your signature also confirms you have read, reviewed, or received Heart Rhythm Solutions *Notice of Privacy Practices* and consent to the terms and conditions set forth.

I authorize the following entities indicated below to disclose and received protected health information to and from Heart Rhythm Solutions.

- Primary Care Physician Name:_____
- Cardiologist Name:_____
- Other Specialist Name:_____

I authorize my medical health information to be released or discussed with the following person(s):

Name	Phone	Relationship
_____	(_____) _____	_____
_____	(_____) _____	_____
_____	(_____) _____	_____

_____
Patient or Legal Representative Name (PRINT)

_____ _____
Patient or Legal Representative Signature Date (Authorization Valid for 1 year)

FINANCIAL POLICY

Thank you for choosing Heart Rhythm Solutions are your health care provider; we are committed to your treatment being successful.

***Co-payments are due to prior your visit or services being rendered.** We only accept cash and credit cards.
Acknowledgement and agreement of this form with a signature is required prior to services being rendered.

INSURANCE
Our office will bill your insurance company when appropriate. Due to difficulty of obtaining payment from some insurance plans, we may ask you for your assistance in getting your claim paid. Please be advised that it is the responsibility of the patient to verify that we are a participating provider on your insurance plan. If patient insurance is non-participating and patient choses to be seen, patient will be billed and charged as self-pay. At time of service, a valid insurance card and picture ID must be provided to confirm patient identity. If insurance card is not provided at time of service, patient will be considered as self-pay. If patient is billed and no payment is made, account will be turned over to collections and additional late fees may incur in addition to the balance owed. Our office does not refund. Our office is not responsible to explain your insurance benefits or financial responsibility. Please contact your PCP or the toll free number on the back of your insurance card if you need an explanation of your insurance benefits or financial responsibility based on contractual agreement with insurance company.

REFERRALS
It is the patients' responsibility to know whether or not their insurance requires an authorization from their PCP. If so, it is the patient's responsibility to obtain referral from their PCP. Our office requests authorization as a courtesy however **our office is not responsible for obtaining referrals for patients.** If you arrive without a referral, your appointment will be re-scheduled. If you wish to be seen without a referral, you will be considered self-pay and will be subject to the self-pay price schedule. **Our office does not refund.**

ADMINISTRATION FEE
Our office charges fees for writing letters and filling out forms. Below is the fee schedule:

$5 – Single page forms requiring only a signature
$10 – Single page forms require more extensive completion
$20 – Written letters, disability forms, or other comprehensive forms
(i.e., letters to employers, FMLA forms, etc,...)

Notification of forms must be given with a minimum of 48 hours before due date.

_____
Patient or Legal Representative Name (PRINT)

_____ _____
Patient or Legal Representative Signature Date (Authorization Valid for 1 year)