Thank you for choosing TrustCare Heart Clinic for your cardiovascular needs.

PATIENT INFORMATION

Last Name ________________________________ First Name _________________________________ MI _____

Date of Birth ______ /______ /______ Gender ☐Female ☐Male SSN ________ - _______ - ________

Address ____ City _____________ State _____ Zip _______

Phone Home (______) ________________ Work (______) _______________ Cell (______) ________________

BEST FORM OF CONTACT ☐Home # ☐Work # ☐Cell # ☐Email

Student Status (please circle) FT / PT Employee Status (please circle) FT / PT / Retired / Not Employed

Employer ______________________________ Email Address ____

PRIMARY CARE PHYSICIAN

Name _____________________________________

Phone _____________________________________

IN CASE OF EMERGENCY

Name _____________________________________

Phone ____________________________________

Relationship ________________________________

GUARANTOR INFORMATION/LEGAL GUARDIAN

☐ Same as Patient

Last Name ________________________________ First Name ________________________________ MI ______

Date of Birth ______ /______ /______ Gender ☐Female ☐Male SSN ________ - _______ - ________

Address ____ City _____________ State _______ Zip _______

Phone Home (______) ________________ Work (______) _______________ Cell (______) ________________

Employer ______________________________ Email Address ____

RELEASE OF INFORMATION

I understand should I choose to release my medical records to a specific entity and/or person(s), such as family members, I must specifically state so below in writing to be kept in my medical record. I also understand should I want exceptions regarding the release of my records, I must also state so in writing.

Last Name ________________________________ First Name ________________________________ MI ______

Address ____ City _____________ State _______ Zip _______

Phone (______) ______________________ Exceptions ____

A COPY OF THE DETAILED OFFICE POLICIES AND HIPAA POLICIES ARE AVAILABLE AT THE FRONT DESK FOR REVIEW.

INSURANCE POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare Heart Clinic's Insurance Release and Out of Network Policy. I hereby agree with and accept all terms.

PATIENT AGREEMENT & FINANCIAL POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare Heart Clinic's Financial Policy and Patient Agreement. I hereby agree with and accept all terms.

CONFIDENTIALITY POLICY: By signing below, I acknowledge I have been provided an opportunity to review TrustCare Heart Clinic's Confidentiality Policy. I hereby agree with and accept all terms.

MEDICAL RECORDS RELEASE POLICY: By signing below, I acknowledge I have been provided an opportunity to review TrustCare Heart Clinic's Release of Medical Records Policy. I hereby agree with and accept all terms.

CONSENT FOR TREATMENT: By signing below, I acknowledge I have been provided an opportunity to review TrustCare Heart Clinic's Informed Consent. I hereby agree with and accept all terms.

HIPAA: By signing below, I acknowledge that a copy of the Notice of Privacy Practice is available to me upon request. I understand a copy of this consent form may be used with the same effectiveness as the original.

X ____ Date ____ /____ /____

(Signature of patient or patient guardian)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I authorize the release of any information concerning my (or my child's) health care and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. We will file a claim with your insurance company for services provided. In the event of non-payment, you will be responsible for the charges incurred today.

X ____ Date ____ /____ /____

(Signature of patient or patient guardian)

I have read the above statements and I understand the contents that I have read and agree to the terms thereof. I am also aware that a copy of all policies is available to me upon request.

Print Patient Name ____ Date ____ /____ /____

X ____ Relationship _______________

(Signature of patient or patient guardian)

Signature of Witness X ____ Date ____ /____ /____