Fort Worth Heart PA

Patient Registration

Patient Demographics

Patient Name:	DOB:
Address:	SSN:
City, State, Zip:	☐ Male ☐ Female ☐ Other
Home #: Mobile #:	☐ Single ☐ Married ☐ Divorced
Email:	Preferred: ☐ Phone ☐ Email

Employer Information

Employer:	Work #:

Guarantor Information

Guarantor Name (If different from patient):	
Address:	SSN:
City, State, Zip:	Relation:

Emergency Contact Information

Name:	Relation:	Phone #:
Name:	Relation:	Phone #:
Name:	Relation:	Phone #:

Primary Care Physician & Referring Physician Information

Primary Care Physician:	Phone #:
Referring Physician:	Phone #:

Texas Law and Federal Regulations require the following information. Please initial if you decline to provide.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	I Decline to Provide:
Race: ☐ American Indian/Eskimo ☐ Asian/Pacific Islander ☐ African American ☐ White ☐ Other/Multi-Racial	

Patient Registration Continued

Financial Responsibility

Self-Pay Patient (please initialize to verify you will not be using insurance)	Initials:
Primary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone #:
Secondary Insurance Name:	ID:
Subscriber (if different from patient):	Group #:
Address:	Phone:

Pharmacy Information

Pharmacy Name:	Phone #:
Address:	Fax #:
City, State, Zip:	Mail ID (if applicable):

Acknowledgement

The above information is true to the best of my knowledge. I request that payment of authorized Medicare benefits made on my behalf for any services furnished to me by Fort Worth Heart, PA, or on its premises, including physician services. I authorize any holder of information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or other benefits related to these services. I appoint Fort Worth Heart, PA to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

I authorize that payment for any and all medical and/or surgical benefits to which I am entitled through private insurance or any health plans, including major medical benefits, be made to: Fort Worth Heart, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

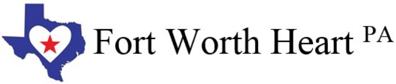
Date: ____________________

Patient: ____

Signature of patient or responsible party

____

Printed name of patient or responsible party



Authorization to Release Protected Health Information/HIPAA Privacy Form

Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient **annually**. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization outlined below.

Patient Name:	DOB:

I AUTHORIZE ____ TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Information Authorized to Disclose:

☐ All health information	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other________________

Initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)	______ HIV/AIDS Test Results/Treatment
______ Genetic Information (including Genetic Test Results)	______ Drug, Alcohol, or Substance Abuse Records

Date: ____________________
Authorization expires 1 year from the date above

Patient: ____
Signature of patient or responsible party

FWH_Downtown	FWH_Burleson	FWH_Boat Club	FWH_Mira Vista	FWH_Granbury
1900 Mistletoe Blvd. Ste. 100	209 Old Highway 1187	4900 Boat Club Rd.	6949 Bryant Irvin Rd. Ste. 110	2003 Rockview Dr.
Fort Worth, TX 76104	Burleson, TX 76028	Fort Worth, TX 76135	Fort Worth, TX 76132	Granbury, TX 76049

Agreement and Assignment of Benefits

Our team of cardiologists, nurses, technicians, and staff look forward to your visit. Fort Worth Heart is proud to offer state-of-the-art diagnostic methods and individual attention to patient needs.

Scheduling Your Appointment
To schedule your appointment, or if you must cancel an appointment, please call (817) 338-1300. Please listen carefully to our menu tree.

Your appointment may include one or more diagnostic tests used to determine how your heart is functioning. Due to the comprehensive exam that will be done, and the possible need for diagnostic testing, you should wear comfortable clothing and shoes. Additionally, to help our cardiologists develop a treatment plan that is best for you, it is necessary that you <u>bring all of your current medications with you to every visit.</u>

On occasion, our doctors become involved in unscheduled emergencies away from the office. If this should occur during your appointment time, every effort will be made to accommodate your needs. Depending upon the nature of the emergency, you may be asked to wait for the physician to return, to reschedule your appointment for another day in the near future, or to see another physician at Fort Worth Heart.

Your Appointment
On the day of your appointment, please:

- Bring all medications that you are currently taking
- Wear comfortable clothing and walking shoes
- Bring necessary insurance forms and a current insurance identification card if applicable
- Bring a referral letter if required by your insurance carrier or HMO
- Be prepared to supply insurance co-payment for services rendered
- Bring studies or reports performed by your referring physician
- If you would like a chaperone for your visit, please notify our front desk team

Payment Policy
Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier. Payment plans are available upon request.

Date: ____________________ **Patient:** ____
Signature of patient or responsible party

____
Printed name of patient or responsible party

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Fort Worth Heart, PA creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that I have the right to review the Notice of Privacy Practices before signing this consent (Please request a copy from the receptionist if you wish to review). I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Date: ____________________

Patient: ____
Printed name of patient

____
Printed name of responsible party (if different than patient)

____
Signature of patient or responsible party