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.

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 bring all of your current medications with you to every visit.

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

Payment Policy

As a courtesy to our patients, Fort Worth Heart provides insurance billing services. It is important that patients understand that insurance coverage varies greatly, depending upon the type of policy. Insurance benefits rarely cover the entire cost of a patient's visit. We expect our patients to pay all uncovered costs incurred under our care. We thank you for your cooperation in this matter.

If your insurance carrier requests a referral letter from your primary care physician, it must be presented to the receptionist upon your arrival. Your insurance carrier will not honor a claim unless these steps are followed. Failure to secure such a letter will result in greater uncovered costs and larger out of pocket expenses for you.

If you do not have health insurance, please contact our billing office prior to your appointment to arrange payment options.

Patient Information

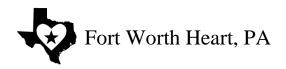
		Cardiologist: Date:				
Personal Informat	ion					
Name						
	First	Middle	Last		E-Mail Address	
Address						
	City		State		Zip	
Home Phone		Cell Phone		Male	Female	
					Status	
Employer						
	City		State		Zip	
Employer Phone			Occupation			
Nearest Relative No	t Living with You _			Relationship _		
Address						
City		State	Zip	Phone _		
Spouse Information	a (ar Parant/Cuardi	on if Potiont is	s a Minor)			
Name				Cell	Phone	
Phone			Occupation			
Family Doctor Name			Phone			
Insurance Informat Insurance Company			Group/Policy #		ID#	
			Group/Policy #		ID#	
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on its premises, includ Administration and its	ing physician services. agencies any informati	I authorize any lion needed to de	holder of information a termine these benefits of	bout me to release to the or other benefits related	ne by Fort Worth Heart, PA, or he Health Care Financing to these services. I appoint enial of services or denial of	
Signature of Patient_				Date		
to which I am entitled This assignment will re	through private insurar emain in effect until re that I am financially res	nce or any health voked by me in v sponsible for all	plans, including major writing. A photocopy o charges, whether or no	r medical benefits, be m f this assignment is to b	edical and/or surgical benefits hade to: Fort Worth Heart, PA. be considered as valid as the company. I hereby authorize	
Signature of Patient			Date			



Fort Worth Heart, PA including physicians and staff, provides cardiac care *only*. We do not provide any general medical or non-cardiology care or checkups. We therefore require all of our patients to have a primary care physician (internal medicine, family practice, general practice, etc.).

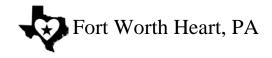
Fort Worth Heart, PA considers it to be your responsibility to have a primary care physician and to have your health care provided and monitored under their direction, as we do not provide those services.

1 acknowledge that I have read and understand	i the above.		
Printed Name	Signature		
Date	Date of Birth		
para el Corazon. No proveemos cuidados de n Corazon o revisions rutinarias. Por lo tanto no tengan us doctor de cabecera (medicina intern La clinica Fort Worth Heart, PA considera que cabecera para el cuidado de salud y bajo el dir			
ya que nosotros no ofrecemos esos servicios. Yo reconozco que he leido y he entendido la p	parte superior.		
Nombre	Fecha		
Firma	Fecha de nacimiento		



Acknowledgement of Privacy Notice

Patient Name:
Date of Birth:
Social Security Number:
I acknowledge that Fort Worth Heart provided me with a written copy of their Notice of Privacy Practices.
I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.
Patient Signature
Date
Personal Representative Signature (if applicable)
Relationship to Patient



information must be filled out on	each patient ann	ually.				
Patient Name:						
Date of Birth:						
I authorize Fort Worth Heart, PA claim and coordinate or manage navailable to my treating physician. In the event a family member or comy evaluation or treatment, I give to discuss freely my condition, tree	ny healthcare. I use electronically varegiver attends a Fort Worth Hea	understand that my medica via a secure health informa my office visit and is in that, art, PA and its physicians,	al information will be ation exchange. the exam room at the time of			
		May we leave a message at this number regarding appointments, test results, prescriptions, etc.?				
Home Phone:		YES	NO			
Office Phone:		YES	NO			
Call Dhamas		VES	NO			
With whom may we discuss or rel		n about care, treatment, or	diagnosis? Phone Number			
Signature (valid one year from da	ite)	Date				
Witness						

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following