

PATIENT REGISTRATION



Chart #	Date		
Patient's Last Name	First Name	MI	Nickname
Street Address	P.O. Box/Apt No.		
City	State	Zip	
Employed: Yes [] No []	Full Time Student Yes [] No []	Sex: M [] F []	
Phone #	Work/Cell Phone		
Date of Birth	Social Security #		
Referring Physician	Primary Care Physician		
Number of Insurance Plans	Name of insured if different from above		
Patient's Relationship to Insured	Insured's SS#		
Insured's Date of Birth	Insured's Employer		
Contact in Case of Emergency	Relationship		
Phone #	Work/Cell Phone		

CONSENT TO TREATMENT

By signing this registration form, I request and consent to medical evaluation and treatment by medical providers and staff employed by The Heart Clinic, P.D. (THC). I understand that I have the Right to refuse, withdraw, or transfer the responsibility of my treatment at any time and agree to inform THC of any such decision

ASSIGNMENT OF BENEFITS

By signing this registration form, I agree to pay THC promptly for any fees incurred for services rendered by THC and its employees. I assign all insurance benefits to THC and authorize release of any medical information necessary to process my claims. I certify that the information provided is true, accurate and complete.

I understand and acknowledge that insurance is filed as a courtesy and balances due after insurance will be my responsibility. This includes deductibles, co-payments, and any non-covered services at the time of each visit.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

By signing this registration form, I acknowledge receipt of THC's Privacy Policy Notice. I understand my rights to privacy and know if I have any questions or specific requests that I may direct them to THC's Privacy Officer or Office Manager, who may be reached at 770-739-0999.

I consent for THC to discuss my protected health information with the following members, significant other or friends:

Name	Relationship
Phone #	Work/Cell Phone
Name	Relationship
Phone #	Work/Cell Phone

Signature	Date
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