Date _____

How did you hear about HeartPlace?

☐ Physician Referral ☐ Advertisement

☐ Friend ☐ Other Please Specify _____

HeartPlace
The Future Of Cardiology Is Here
A Professional Association managed by Cardiovascular Provider Resources

For Office Use Only

Verified Date _____

By: _____

System Account # _____

Date/By: _____

Patient Information

Name _____ Doctor _____
last first middle

Social Security # _____ Email Address: _____

Address _____ City _____ State ____ Zip _____

Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____

☐ Married ☐ Single ☐ Widow ☐ Divorced Age _____ Date of Birth _____ ☐ Male ☐ Female

Employer Name _____ Employer Address _____

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self-Employed ☐ Student - Fulltime ☐ Student - Parttime

Referring Physician _____ Referring Physician Ph. (____) _____

Primary Care Physician _____ Primary Care Physician Ph. (____) _____

Insured Name (If no insurance, responsible party)

Name _____ Relationship _____

Social Security # _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Home Ph. (____) _____ Business Ph. (____) _____ Cell Ph. (____) _____

Employer Name _____ Employer Address _____

Notify In Case of Emergency

1. Name _____ Relationship _____ Home Ph. (___) _____ Business Ph. (___) _____

2. Name _____ Relationship _____ Home Ph. (___) _____ Business Ph. (___) _____

Insurance Information - Copies of Insurance Cards and Drivers License are Required

Insurance 1 _____

Address _____ Phone (___) _____

SS# _____ Policy # _____ Group # _____

Insurance 2 _____

Address _____ Phone (___) _____

SS# _____ Policy # _____ Group # _____

Authorizations

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the reciept of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed _____ Date _____

Patient Name (Please Print) _____

Witness Signature _____ Date _____