ADVANCED
HEART RHYTHM CARE
Cardiac Electrophysiologist

Patient Information

First Name | Middle Name | Last Name

Date of Birth | Sex | SS # (for insurance & hospital) | Home Phone | Cell Phone

Primary Address | City | State | Zip

Alternative Address | City | State | Zip

Email | Send results, billing & appointment info via email? Yes No

Ethnicity: Not Hispanic Hispanic/Latino I Prefer Not To Reply

Race: American Indian/Alaska Native Asian White Black/African American Pacific Islander Other

Marital Status: Married Single Preferred Language: _____

Pharmacy | Phone | Address/Intersection if no phone

Primary Doctor | Cardiologist (First and Last Name)

Emergency Contact

Relationship | Phone

Names of Family / Friends we have permission to share your test results with: _____

Financial Responsible Party

Is the Patient the financially responsible party? Yes No If No, Complete the Section Below

First Name | Middle Name | Last Name

Relationship | Phone

How did you hear about us?: _____

SIGNATURE | Date

P: 941.396.3287 • F: 941.424.1741 • advancedheartrhythmcare.com

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Heart Rhythm Consultants P.A., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Heart Rhythm Consultants. I understand that diagnosis or treatment of me by Heart Rhythm Consultants may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review the Heart Rhythm Consultants, Notice of Privacy Practices prior to signing this document. The Heart Rhythm Consultant P A Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment, of my bills or in the performance of health care operations of Heart Rhythm Consultants P A. The Notice of Privacy Practices for Heart Rhythm

Consultants P.A. is also provided at 1921 Waldemere St., Suite 301, Sarasota, FL 34239. This Notice of Privacy Practices also describes my rights and the duties of Heart Rhythm Consultants P A, with respect to my protected health information. Heart Rhythm Consultants P.A. reserves the right to change privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Heart Rhythm Consultants P.A., or asking for one at my next scheduled appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Heart Rhythm Consultants P.A. (HRC) for any charges not covered by healthcare benefits. It is my responsibility to notify HRC of any changes in my healthcare coverage. In some cases exact insurances benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill as determined HRC and/or my insurance company if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Heart Rhythm Consultants P.A. (HRC) for all covered medical services provided to me during all courses of treatment and care provided by HRC. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with HRC, which will authorize and allow for direct payment to HRC of all applicable and eligible insurance benefits for all subsequent and continuing treatment provided to me by HRC.

Acknowledgment of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Heart Rhythm Consultant's Notice of Privacy Practices, which describes how HRC will use and protect my health information. This notice describes my rights under the Health Insurance Portability and Accountability (HIPPA) and HRC's policies on use and disclosure of my protected health information.

Name	Name of Personal Guardian/Representative
Signature of Patient	Signature of Personal Guardian/Representative
Date	Date

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Authorization for Release of Medical Records

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW

I, _____. hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

_____

Record Number | Patient's Date of Birth | Patient's SSN

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

_____

This Information is to be Provided to:

_____

Name of Person/Organization/Facility

_____

Address | Phone Number

1. I understand that this authorization will expire on (insert date)_____.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying (insert name of practice)_____ in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____

Patient's Signature or Patient's Representative | Date

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.