The Heart Center Cardiology
2375 Champions Blvd, Auburn, AL 36830

PATIENT INFORMATION SHEET

Name _____
Last First Middle

Address _____ City _____ ST _____ ZIP_____

Home Telephone # _____ The clinic may use this number to contact me. Yes No

Cell Telephone # _____ The clinic may use this number to contact me. Yes No

Work Telephone # _____ The clinic may use this number to contact me. Yes No

Social Security # _____Date of Birth ___/___/_____ Sex _____ Race _____

Marital status (Please circle) S M D W Email address _____

Patient/Parent Employer _____ Occupation _____

Employer Address _____

Name of Spouse _____SS# _____ DOB____/_____/_____

Spouse Business # _____ Spouse Cell # _____Spouse Employer: _____

Primary Care Physician _____ Clinic Location _____

Referring Physician _____ Clinic Location _____

Name of your pharmacy _____City_____Telephone #_____

General Health Questions:

Diet	Regular	Vegetarian	Vegan	Gluten Free	Cardiac	Diabetic
Do you have high cholesterol?	Yes	No				
Alcohol Intake	None	Occasional	Moderate	Heavy	Years of use_____	
Smoking Status	Never smoked	Former Smoker	Every day smoker	Some day smoker	Unknown if ever smoked	
	Has smoked since age _____					
If you smoke, how much?	1 pack/week	2 pack/week	¼ pack/day	½ pack/day	1 pack/day	
	1.5 pack/day	2 pack/day	3+ pack/day			
Chewing tobacco	None	1/day	2-4 day	5+ day	Tobacco years of use _____	

I, the undersigned patient/responsible party, give The Heart Center Cardiology permission to download a listing of my current medications electronically.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Witness Date

The Heart Center Cardiology, PC

Financial Policy

Thank you for choosing The Heart Center Cardiology, PC as your cardiovascular specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part. We ask that all responsible parties read and sign our financial policy prior to seeing the physician. Payment for all services will be due at the time services are rendered. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-pays, covered charges, second insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.
2. Fees for services, which include unpaid balances, deductibles and co-pays and in some cases co-insurance, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.
3. All charges are your responsibility whether your insurance company pays or does not pay. If any payment is made directly to you for services billed by The Heart Center Cardiology, PC, you recognize an obligation to promptly remit payment to The Heart Center Cardiology.
4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by The Heart Center Cardiology, PC, I will be responsible for all costs of collecting monies owed, including collection agency fees.
5. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.
6. We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing.

ASSIGNMENT OF BENEFITS: I/We, the undersigned authorized benefits from Medicare, Medicaid and all Commercial insurance companies be made on my behalf to The Heart Center Cardiology, PC for any services furnished to me.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____ Patient Date of Birth: _____

_____	___/___/_____	_____
Signature of Patient or Responsible Party	Date	Relationship, if other than the patient

_____	___/___/_____	_____
Signature of Witness	Date	Time

2375 Champions Blvd
Auburn, AL 36830
Telephone 334-321-3700

John W. Mitchell, M.D.
David A. Pate, CRNP

AUTHORIZED PATIENT NOTIFICATION LIST
Requirement of HIPAA (Health Insurance Portability and Accountability Act)

I authorize The Heart Center Cardiology, PC and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

Name	Relationship	Contact Number

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorization Notification List.

PATIENT/OTHER PERSON AUTHORIZED TO SIGN _____ DATE _____

RELATION TO ABOVE SIGNATURE _____

WITNESS SIGNATURE _____ DATE _____ TIME _____

Authorization to Disclose Protected Health Information

The undersigned authorizes

THE HEART CENTER CARDIOLOGY

2375 CHAMPIONS BLVD ● AUBURN, AL 36830

Phone: 334-321-3700 ● Fax: 334-887-7475

to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names? _____

Patient Address: _____ **Date of Birth: _____**

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email.

Name/Facility: _____ Attention: _____

Address: _____ **Phone: _____**

City: _____ State: _____ Zip: _____ **Fax** #: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

☐ **Date Range**: _____:

- □ Progress Notes □ Radiology Reports □ Labs
- □ Operative Reports □ Injections □ Physical Therapy
- □ Other: _____

A valid email must be provided above. If you do not select a delivery method, BACTES will determine the delivery method based on the information provided on this form.* **No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, we may be unable to fulfill this request.

Signature*:_____ Date: _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

2375 Champions Blvd, Suite 201
Auburn, AL 36830
Telephone 334-321-3700

The Heart Center

John W.Mitchell, MD.
David A. Pate,.CRNP

You have a right to review The Heart Center Cardiology, PC Privacy Notice prior to signing this receipt.

BY SIGN1NG BELOW,I HEREBY ACKNOWLEDGE *RECEIPT* OF THIS PRIVACY NOTICE.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient's Representative (if signed by Patient's Representative)

_____
Representative's Relationship to Patient (If signed by Patient's Representative)

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To be completed by The Heart Center Cardiology, PC

After good faith attempt to obtain an Acknowledgment Receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

_____

_____ _____
Signature of THCC Representative Date