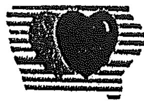

IOWA • HEART • CENTER, P.C.

Registration Staff: ________
Date: ________

PATIENT INFORMATION

Patient's Name: ____________________ (last / first / middle initial / maiden) Sex ☐ M ☐ F

Address: ____________________ (street / apt. / city / state / zip)

Hm Phone: ________ Wk Phone ________ Birthdate ________ Age ____ Marital Status S M W D Sep

Social Security No. ________ Retired: ☐ yes ☐ no If so from where: ________ Date: ________

Employer ________ Occupation ________ Student ☐ yes ☐ no

Employer Address: ____________________

Emergency Contact (other than spouse) ____________ relationship Phone # ________

SPOUSE OR PARENT INFORMATION - *(please circle one)*

Name: ____________________ (last / first / middle) Relationship to patient: ________

Retired: ☐ yes ☐ no If so, date of retirement ________

Employer Name: ________ Employer Address: ________

Work Phone (____) ________ Social Security No. ________ Birthdate ________

REFERRAL INFORMATION

Family Doctor ________ Address ________

If family doctor did not send you please list referring Dr. / Address ________

NSURANCE INFORMATION - *PLEASE PRESENT INSURANCE CARDS AT CHECK IN*

Does your insurance company require a referral to a specialty office ☐ yes ☐ no

Primary Insurance: ________ Grp # ________ Policy # ________

Address: ________ Policy Holder: ________

Secondary Insurance: ________ Grp # ________ Policy # ________

Address: ________ Policy Holder: ________

IF YOU HAVE MEDICARE - PLEASE ANSWER THE FOLLOWING:

1. Are you or your spouse working on or after 65th birthday? ☐ yes ☐ no
2. Are you entitled to benefits under the Federal black lung program? ☐ yes ☐ no
3. Did you ever have an illness due to an injury that resulted from your occupation? ☐ yes ☐ no
4. Did you become entitled to Medicare benefits solely on the basis of end-stage renal disease? ☐ yes ☐ no
5. Does your Medicare card say (Part A / hospital only) ☐ yes ☐ no

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I HEREBY AUTHORIZE EXAMINATION AND ANY OTHER MEDICAL SERVICES DEEMED NECESSARY BY IOWA HEART CENTER, P.C. I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO IOWA HEART CENTER, P.C. FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OR EVALUATING AND ADMINISTERING CLAIMS OR BENEFITS.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO IOWA HEART CENTER, P.C. FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES

PATIENT SIGNATURE ____________________ DATE ________

Patient Profile page 2

Doctor: ______________ Patient ID #: ______________

Name: ______________ Date of Birth: ______________

Phone: ______________ [ ]Home [ ]Work [X]Other Social Security #: ______________

Billing and Insurance Policies

1. As a courtesy to our patients we will automatically file your insurance for you, with the exception of our screening services, such as vascular screening and calcium scoring, unless you advise us differently.
2. Statements will be mailed on a monthly basis once your acount has a balance for which you are responsible. Payment or payment arrangement is expected within 30 days of the initial statement.
3. Your insurance contract is an agreement between you and your insurance carrier. We will assist you, within our limits, if negotiation is needed to settle your claims. Any overpayment to your account will be refunded to the appropriate payor.
4. Patients who do not have insurance coverage must establish a payment plan on/or before the day they receive services. To insure that the account will not be sent to an outside collection agency, payment must be made within 60 days.
5. Please contact our office with any concerns you may have about your bill. We will be glad to discuss payment arrangements with you. Our Customer Service staff can be reached at 633-3800 or toll free at (888-884-8286).

Medicare Insurance

IF YOU HAVE MEDICARE - PLEASE ANSWER THE FOLLOWING:

1. Are you or your spouse working on or after 65th birthday? YES NO
2. Are you entitled to benefits under the Federal Black Lung Program? YES NO
3. Did you ever have an illness due to an injury that resulted from your occupation? YES NO
4. Did you become entitled to Medicare benefits solely on the basis of end-stage renal disease? YES NO
5. Does your Medicare card say (part A only)? YES NO

Private Insurance Authorization for Assignment of Benefits and Information Release

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Patient Signature: ______________ Date: ______________

IOWA HEART CENTER, P.C.

Acct #

Please Print Name: ______________________ Date of Birth: ______________

▪ Acknowledgement of Receipt of Notice

By signing below you are acknowledging that you have received a copy of the Iowa Heart Center P.C. Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

▪ Permission for Verbal Disclosure

If you would like to give Iowa Heart Center P.C. staff permission to discuss your care with someone please indicate below.

I, the undersigned, authorize the Iowa Heart Center P.C. to verbally disclose my Protected Health Information to the following individual(s) or entities. I understand that this permission only applies to verbal / spoken communication to include but not limited to: discussion of my treatment plans, medications, test results, and upcoming procedures. I further understand that disclosure of copies of my medical record, or other written forms of my protected health information, will require my written authorization for each episode of release. This permission will become a permanent part of my medical record.

Name: ______________________ Ph# ______________

Relationship: ______________________

Name: ______________________ Ph# ______________

Relationship: ______________________

The individual / entity named above may receive oral disclosures about:

☐ All protected health information without restriction

☐ Other (specify): ______________________

▪ Permission for Iowa Heart Center to Leave a Message

Iowa Heart Center utilizes an automated system to call and confirm appointments. If an answering system picks up this call a message will be left automatically. Other than these appointment reminders, is it alright for Iowa Heart Center to leave messages containing our contact information?

☐ No- please do not leave a message on any answering system

☐ Yes- a message may be left on my home answering machine @ Ph# ______________

☐ Yes- a message may be left on my work answering machine @ Ph# ______________

☐ Yes- a message may be left on my Cell answering service @ Ph# ______________

I understand that while verbal revocations will be accepted a written revocation will be necessary for documentation purposes. Other than revocation, any changes requested will require written notification to the Iowa Heart Center P.C. I also understand that any release made prior to my revocation which was in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Patient / Legal Representative Signature:

______________________ Date: ______________

Relationship if other than patient: ______________________

IHC.ADMN.644/0306