

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE I: _____

MAIDEN NAME: _____ SEX: M / F MARITAL STATUS: S M W D

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

WORK PHONE: (____) _____ EXT: _____ Can you be contacted at work? Y / N

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURED- INFORMATION

(Please have insurance cards available for copying and verification)

INSURED LAST NAME: _____ FIRST NAME: _____ MIDDLE I: _____

INSURED ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE PLAN NAME: _____ ID #: _____

INSURANCE GROUP #: _____ OFFICE CO-PAY AMOUNT: _____

INSURED SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

INSURED SEX: M / F HOME PHONE: _____ WORK PHONE: _____

INSURED EMPLOYER NAME: _____

SECONDRY INSURANCE CARRIER – INFORMATION

INSURED LAST NAME: _____ FIRST NAME: _____ MIDDLE I: _____

INSURANCE PLAN NAME: _____ GROUP #: _____ ID #: _____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY NUMBER: _____

PATIENT SIGNATURE: _____ Date: _____

If you wish to provide an Emergency Contact: Name: _____ Relationship: _____
Phone: _____

Mid America Heart is allowed to leave a message on my answering machine? [] yes [] No

Mid America Heart may discuss my medical information with

Name: _____ Phone: _____

Name: _____ Phone: _____

TURN SHEET OVER

PLEASE READ POLICY AND RELEASE

INITIAL AND SIGN WHERE INDICATED

Reviewed by: _____

Date: _____

OFFICE POLICY

Payment is due at the time of service on all office visits unless prior arrangements have been made. We will file your secondary insurance. All other insurance coverage is filed as a courtesy to our patients. If you are covered under an HMO/PPO plan, it is YOUR responsibility to obtain the proper referrals. You will be responsible for any charges that are not covered under the companies' guidelines or charges where proper referrals were not obtained.

PATIENT INITIALS: _____

POLICY FOR NON-PAYMENT FOR SERVICES: . Non-payment for services is defined as an account on which a patient balance is outstanding and there has been no effort by either the patient or responsible party to make satisfactory payment on the account. It is our policy that routine healthcare will not be provided in this office when a patient has a history of non-payment for services. Although routine healthcare will not be provided, emergency care in an emergency room setting may be provided. I understand that I will be held responsible for any extraordinary collection cost, lawyers' fees, and all legal fees should my account be sent to a collection agency or other institution for collection. I have also read and understand the Policy for Non-Payment for Services.

PATIENT INITIALS: _____

POLICY FOR UPDATEING REGISTRATION INFORMATION: It is the policy of office to have a patient registration form completed every two years. This office may request updated copies of your insurance cards at any time. Please bring your insurance cards with you at each visit.

PATIENT INITIALS: _____

Please read and sign the consent form below. This is a standard consent form that will be kept in your records to submit claims on your behalf.

RELEASE AND ASSIGNMENT

310 N. Seven Hills Road, Suite 150; O'Fallon, IL 62269

I hereby authorize Mid America Heart, P.C. to release third party/parties and/or their representatives any information necessary in order for claims for payment of services provided to me. I also authorize and request my insurance company to pay directly to Mid America Heart, P.C. or the above physicians the amount due me in my pending claim for Basic Medical, Major Medical, and/or Surgical Treatment of Services by reason of such treatment or services rendered to me.

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____

Reviewed by: _____ **Date:** _____