BIRMINGHAM HEART CLINIC, P.C.

PATIENT REGISTRATION

MR.
MS.
MRS.

LAST NAME | FIRST NAME | MIDDLE

SOCIAL SECURITY NUMBER | AGE | RACE | ETHNICITY | DATE OF BIRTH

STREET ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

EMPLOYER'S NAME | EMPLOYER'S ADDRESS | BUSINESS PHONE NUMBER

EMAIL ADDRESS

SPOUSE'S NAME | SPOUSE'S DATE OF BIRTH

REFERRED BY

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

LAST NAME | FIRST NAME | MIDDLE

SOCIAL SECURITY NUMBER | AGE | DATE OF BIRTH

STREET ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

EMPLOYER'S NAME | EMPLOYER'S ADDRESS | BUSINESS PHONE NUMBER

INSURANCE INFORMATION (Please fill out ONLY if insurance cards are not present.)

INSURANCE COMPANY	POLICY OR CONTRACT #	GROUP NUMBER	INSURED NAME

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I, the undersigned, authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or with any public agency and its agents to determine benefits for services provided and/or benefits for related services.

NOTICE OF PRIVACY PRACTICES: I, the undersigned, acknowledge that I have been offered and/or received a copy of Birmingham Heart Clinic's "Notice of Privacy Policies".

PRIOR CONSENT TO CONTACT: I, the undersigned, give Birmingham Heart Clinic, its employees and/or agents, "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment or benefits be made directly to Birmingham Heart Clinic, P.C. for services provided to me by Birmingham Heart Clinic, P.C. I understand that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event my account (Patient Balance) becomes delinquent (in excess of 90 days old), I accept and agree to pay any/all collection agency fees, (33.33%), including attorney fees and/or court costs if necessary.

DATE: _____ X _____

Birmingham Heart Clinic, P.C.
Cardiovascular Disease Data Sheet

Full Name: _____ Date: _____

Age: _____

Are you or have you ever been treated for:
{__} High Blood Pressure
{__} Diabetes
{__} High Cholesterol

Please list previous surgeries:
_____
_____
_____

Any other medical conditions? _____
_____

Current Medications:

Medication Name	Mgs	Number you take each time	Number of times you take per day	If recently stopped, last date taken

ALLERGIES

Are you allergic to any drugs? Yes No

_____
_____
_____

Have you ever had a reaction to x-ray dye such as given for kidney x-rays? ☐ Yes ☐ No

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HABITS

Tobacco Smoking (check one)

☐ Never Smoked
☐ Used to Smoke If so, year that you quit smoking: _____ (m/y)
☐ Currently Smoking

Alcohol:

☐ Yes _____ drinks/day _____ drinks/month
☐ No

SOCIAL HISTORY:

Education Completed: _____

Marital Status: _____ Single _____ Married _____ Separated
_____ Divorced _____ Widowed

Present Occupation: _____

FAMILY HISTORY:

Father: Age, if living: _____ Age at death: _____
Medical Problems: Cause of Death: _____

{ } High Blood Pressure
{ } High Cholesterol
{ } Diabetes Mellitus
{ } Heart Attack
{ } Congestive Heart Failure

Mother: Age, if living: _____ Age at death: _____
Medical Problems: Cause of Death: _____

{ } High Blood Pressure
{ } High Cholesterol
{ } Diabetes Mellitus
{ } Heart Attack
{ } Congestive Heart Failure

How many brothers?_____ How many sisters? _____

Are they all living? If not, age at death and cause of death? _____

_____

Do your siblings have any of the following medical conditions (check all that apply)?

{ } High Blood Pressure
{ } High Cholesterol
{ } Diabetes Mellitus
{ } Heart Attack
{ } Congestive Heart Failure

What doctor referred you? _____

What doctors should receive a letter regarding the results of your appointment today?

_____

AUTHORIZATION FOR PAYMENT:

I hereby authorize payment directly to the provider of services, and I understand that I am responsible for medical charges, co-pays and/or deductibles not covered by my insurance company.
I am aware that I, not my insurance company, am responsible for the entire account. I understand that my insurance is a contract only between my insurance company and myself and not with ***Birmingham Heart Clinic, P.C.***

AUTHORIZATION TO OBTAIN MEDICATION HISTORY:

I hereby authorize ***Birmingham Heart Clinic, PC*** to obtain my medication history from my pharmacy, health plans, and other healthcare providers. By signing this consent form I am giving ***Birmingham Heart Clinic, PC*** permission to collect and the pharmacy and other health insurer permission to disclose information about my medications that have been filled at any pharmacy or covered by any health insurance plan.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to release medical information such as office notes and/or test results to myself, person (s) listed below and/or other physicians assisting with my medical care until notified otherwise.

AUTHORIZATION TO RELEASE TEST RESULTS:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to discuss my medical condition and/or test results:

Please check all that apply: ___only to myself
___ leave test results on answering machine
___ release only to the following persons:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

*

_____ _____
Patient's Name *(please print)* D/O/B

*

_____ _____
Patient's Signature Date

_____
Witness

(This authorization is valid unless notified in writing by the patient.)

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Birmingham Heart Clinic, PC
100 Pilot Medical Drive Suite 300
Birmingham, AL 35235

Phone: 205-856-2284
Fax: 205-815-4777

** AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION **

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT NAME:_____

DATE OF BIRTH:_____ SSN:_____

Please identify those persons/organizations to receive your information:

_____

Please provide a specific description of your information to be used or disclosed (identification, including date(s):

_____

Please provide a statement describing each purpose for the requested use or disclosure of your information:

_____

Section B: Must be completed for all authorizations
The patient or patient's representative must read and initial the following statements:
a) I understand that Birmingham Heart Clinic, P. C. will not condition my treatment (and, if applicable, payment for my health care, my enrollment in a health plan, or eligibility for benefits) on whether I provide authorization for the requested use or disclosure-except in limited circumstances (e.g. if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party, such as physical examinations for school, camp, and employment purposes).
Initials:_____

b) I understand that I may revoke this authorization at any time by notifying Birmingham Heart Clinic, P.C. in writing; however, such revocation does not affect any actions taken by Birmingham Heart Clinic, P.C before Birmingham Heart Clinic, P.C. received my written revocation.
Initials:_____

c) I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.
Initials:_____

d) I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
Initials:_____

e) I understand that this authorization will expire on _____(identify date) or _____(identify expiration event).
Initials:_____

f) I understand that this authorization is voluntary and that I have the right refuse to sign this authorization.
Initials:_____

*

_____ _____

Signature of Individual or Personal Representative of Individual Date

Printed Name of Personal Representative:_____
Relationship of Personal Representative to Individual:_____

You may refuse to sign this authorization