The Good Heart Corporation

Full Name:____

Date of Birth:_______________ Sex: M F SS#:__________________

Ethnicity: Caucasian African America Asian American Indian Hispanic

Preferred Language: English Spanish Other:__________________

Telephone:___________________ Cell phone:_____________________

Mailing Address:____

City:______________________ State:_________ Zip:_____________

Physical Address:____

City:____________________ State:_________ Zip:_______________

Email Address:____

Communication Preference: Mail Email Phone

Employer:_____________________ Work Telephone:______________

*Do you currently use tobacco: Yes No

If YES, what kind of tobacco:___________________________________

If YES, how much tobacco do you use daily:______________________

*If NO, have you ever smoked: Yes No

If YES, how long ago:____

*Do you currently use any alcohol: Yes No

If YES, how much alcohol do you consume:_______________________

Referring/Family Physician:____________________________________

Telephone Number:____

Pharmacy:____

Alternate/Emergency Contact Name:	Phone Number	Relation
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

1st Insurance:_______________________ Insured Name:______________________
Date of Birth:_______________________ SS#:_________________________________
Insurance ID#:__________________________ Group #:________________________

2nd Insurance:_______________________ Insured Name:______________________
Date of Birth:_______________________ SS#:_________________________________
Insurance ID#:________________________ Group #:__________________________

Person responsible for account not covered by insurance:______________________

CONSENT TO TREAT, INSURANCE ASSIGNEMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICIAL PROCEDURE:** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but not limited to laboratory procedure, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. _______________(initials)
2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:** In consideration of services rendered, I hereby transfer and assign to Health First Physicians all rights, title, and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer)._______________(initials)
3. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient's general agent to execute the above and accepts its terms. _______________(initials)
4. **MEDICARE/MEDICAID:** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needs for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _______________(initials)
5. **USE OF COPIES:** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic. _______________(initials)
6. **PAYMENT RESPONSIBILITY:** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _______________(initials)

I have read, understand, and agree to the above legal and binding document:

Print Name:____

Signature:____

Date:___________________________

Good Heart Corporation
1380 Hwy 192 East
London, Kentucky 40741
606-330-0050

HIPAA RELEASE:

In accordance with federal government HIPAA Privacy Standard for releasing information concerning you, even to a spouse, family member, or friends, we must have your signed permission in order to release any information. Please read the following statement, list any persons to whom you give permission to receive any information about you, and sign the form below.

I give permission to have information concerning my medical treatment, prescriptions, appointments, and/or billing issues released to the following persons:

1. Name:______________________________ Phone:_______________
2. Name:______________________________ Phone:_______________
3. Name:______________________________ Phone:_______________

Patient Name:____
Date of Birth:____
Patient Signature:____
Date:___________________________

Good Heart Corporation
1380 Hwy 192 East
London, Kentucky 40741
606-330-0050

HIPAA Acknowledge of Receipt of Notice or Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review a copy of our notice, and we must show acknowledgement form that we gave you a copy of our notice. The terms of our notice may change as the HIPAA Final Rule is updated, and you will be able to review an updated copy each time changes are made. A copy of our Notice of Our Privacy Practices will be posted in the lobby of each of our office locations.

You have the right to request that we restrict how we use Protected Health Information about you for treatment, payment, and health care operation. We are not required to agree to this restriction if your request is not feasible or it impedes our ability to provide the treatment you need, but if we do accept your request, we shall honor that agreement.

The Good Heart Corporation provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

By signing this acknowledgement, I understand that:

- Good Heart Corporation has a Notice of Privacy Practices and I have received a copy of this notice.
- Protected Health Information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the Notice of Privacy Practices.

I acknowledged receipt of the Notice of Privacy Practices.

Printed Name of Patient or Representative:____

Signature:____ Date:____________________

Relationship to Patient (if other that patient):____

O Check if patient refused to take a copy of the Notice of Privacy Practices

Witness Print Name (practice representative):____

Witness Signature:____ Date:____________________

Insurance Billing Policy – Updated 7/14/2014

To our valued clients:

As a courtesy to our patients, we will file a claim to your insurance company for payment of services provided. We strive to meet all the requirements of each insurance company. We are credentialed providers of most insurance companies. We will attempt to obtain any precertification required for your procedures, and in a timely manner, however, billing is a courtesy. The final responsibility for payment of services rendered lies with the recipient of services. If for any reason your insurance claim is denied, we reserve the right to bill you, the client, for the services provided.
Most insurance companies require that we collect co-payment for services provided in the clinic. It is a violation of federal law for copays to be waived. The penalties involved for us are stiff, including fines and penalties for us, and exclusion from your policy for you. Co-payment is due when services are rendered. We accept cash, check, and all major credit cards as forms of payment. We are required to collect all balance(s) due within six months, otherwise, we must use collection services that report to all major credit bureaus.

Thank you for your business!

Good Heart Corporation

If your account is more than 150 days past due, it may be referred to a collection agency. This is used as a last resort reluctantly after we have exhausted efforts for voluntary payments.

Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be scheduled, or you may be financially responsible.

Acknowledgement and Authorization: I have read, understand, and agree to the above payment policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to The Good Heart Corporation.
I authorize The Good Heart Corporation to release any medical or other information to my insurance company when requested.

Printed Name:____

Signature:____

Date:__________________________________