Georgia Heart Specialists

Mark C. Hanson, M.D., F.A.C.C.
Michael P. Cecil, M.D., F.A.C.C.
Enrique A. Flores, M.D., F.A.C.C.
James S. Abraham, M.D., F.A.C.C.

## Patient Information

**Patient Name:**
**Street Address:**
**Mailing Address:**
**Home Phone:**
**Work Phone:** **Cell Phone:**
**Date of Birth:** **Social Security Number:**
**Marital Status:** **Email Address:**
**PCP Doctor:**
**Georgia Heart Specialists Physician:**
**Race:** **Ethnicity:** ☐ Hispanic or Latino
**Language:** ☐ Not Hispanic or Latino
**Sex:** female ☐ Refuse to Answer

**Please circle which lab your Insurance prefers:** Quest LabCorp Other

## Insurance Information

**Primary Insurance:** **Phone Number:**

**Subscriber Name:** **Date of Birth:**
**Subscriber ID:** **Group Number:**

**Secondary Insurance:** **Phone Number:**

**Subscriber Name:** **Date of Birth:**
**Subscriber ID:** **Group Number:**

## Employer Information

**Employment Status:**
**Employer Name:** **Phone Number:**
**Address:**

## Additional Information

**Emergency Contact Name:** **Phone Number:**
**Pharmacy Name:** **Pharmacy Number:**

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## ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
## AS WELL AS AN APPOINTMENT AS AN ERISA/PPACA REPRESENTATIVE DESIGNATION

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay all of the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of any health insurance or medical plan benefits directly to Georgia Heart Specialists for medical services rendered and for any supplies, tests, or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Georgia Heart Specialists all rights to payment and benefits and all legal and other health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that Georgia Heart Specialists can act on my/our behalf, as our representative, ERISA representative, or PPACA representative as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Georgia Heart Specialists as a result of services rendered by Georgia Heart Specialists, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____ _____

Patient's Name (PRINT) Date of Birth

_____ _____

Patient's Signature Date

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# Patient's Authorization for e-Prescribing

By signing this form, I am giving Georgia Heart Specialists permission to electronically exchange prescription information with pharmacies. I further agree to allow Georgia Heart Specialists to access critically important information on my current and past medications from pharmacy benefit managers and community pharmacies.

_____ _____

Patient's Name (PRINT) Date of Birth

_____ _____

Patient's Signature Date

4140 Tate Street Covington, Georgia 30014 Telephone: 770-786-0077 Fax: 770-786-8750
1366-A Wellbrook Circle Conyers, GA 30012 Telephone: 770-918-0074 Fax: 770-918-9192

# GEORGIA HEART SPECIALISTS, L.L.C.

*Cardiac Consultation, Invasive Cardiology*
*& Nuclear Cardiology*

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## Patient Authorization for Use/Release of Health Information

**By signing this form, I authorize Georgia Heart Specialists, L.L.C. to obtain protected health information described below from:**

Name and Address of Person and/or Organization from Whom Information Should Be Obtained:

_____

_____

_____

This authorization expires upon fulfillment of request

**I authorize the following information to be sent to Georgia Heart Specialists, L.L.C.:**

_____ Copies of all medical records for the period _____ to _____

_____ Copies of the information described below for the period _____ to _____

_____ History & Physical Examination ____ Lab, Xray, Test Reports, Surgery Reports ____ EKG's

_____ Other _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

I understand that Georgia Heart Specialists, L.L.C. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. Therefore, I release Georgia Heart Specialists, L.L.C. from all legal liability that may arise from this authorization.

_____
Print Name

_____ _____ _____ _____
Patient Signature SS # DOB Date

The patient or their representative may revoke this authorization by notifying in writing Georgia Heart Specialists, L.L.C. designated Privacy Officer.

# GEORGIA HEART SPECIALSITS, L.L.C.
## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
## TO THE PATIENT
## PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and of the uses and disclosures we may make of your protected health information. A copy of our Notice is available to you. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our policy practices as described in our Notice of Privacy Practices. If we change our primary practices, we will post a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

With this consent, **Georgia Heart Specialists, L.L.C.** may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Georgia Heart Specialists, L.L.C.**
**Privacy Officer**
**4140 Tate Street**
**Covington, Georgia 30014**

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have the right to request the **Georgia Heart Specialists, L.L.C.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____

Relationship to Patient if signed by anyone other than the patient (parent, legal guardian, personal rep, etc.)