

# SOUTH TEXAS HEART CLINIC PATIENT REGISTRATION

## CONTACT INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
LastFirstMIHome Telephone

Home Address: \_\_\_\_\_ Street      Mailing Address: \_\_\_\_\_ Street

\_\_\_\_\_  
CityStateZipCityStateZip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  M  F SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Married  Single  Other  
SexCheck Marital Status

Employer \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
NameWork Telephone

\_\_\_\_\_  
AddressOccupation

Responsible Party \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
NameRelationshipTelephone

Emergency Contact  
Spouse/Next of Kin \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
NameRelationshipTelephone

## INSURANCE INFORMATION

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Primary Ins: \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DOB \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Ins: \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DOB \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

## ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Timberland Medical Group dba South Texas Heart Clinic. I also authorize agents of any hospital, treatment center or previous physician to furnish copies of any records of my medical history services or treatments to Timberland Medical Group dba South Texas Heart Clinic. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purpose of internal audits, research, and quality assurance reviews with Timberland Medical Group dba South Texas Heart Clinic.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment, rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Timberland Medical Group dba South Texas Heart Clinic. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to Timberland Medical Group dba South Texas Heart Clinic.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law ) may also share with interested third parties. These third parties may include (a) managed care companies, insurance companies and other payors, (b) companies that produce drugs and clinical research companies, (c) governmental bodies (such as Food and Drug Administration, the Health Care Financing Administration), (d) representatives and agents of my health benefit plan, (e) persons conducting quality of peer review of patient satisfaction surveys, and (f) other clinical and non-clinical parties that have a contractual relationship with Timberland Medical Group dba South Texas Heart Clinic.
5. I acknowledge that I have been provided a copy of the HIPAA Notice of Privacy practices for review and understand how my medical information may be used and disclosed.
6. There will be a \$25.00 charge on all returned checks.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.**

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date