TrustCare™
Heart Clinic

Thank you for choosing TrustCare Heart Clinic for your cardiovascular needs!

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Gender: ☐ Female ☐ Male SSN ___-___-___ Marital Status S M D W (please circle one)

Address: _____ City: _____ State: _____ Zip: _____

Phone - Home (___)-___-_____ Work (___)-___-_____ Cell (___)-___-_____

Student Status (please circle) FT / PT Employee Status (please circle) FT / PT / Retired / Not Employed

Employer: _____ E-mail address: _____

PRIMARY CARE PHYSICIAN

Name: _____

Phone - Home (___)-___-_____

IN CASE OF EMERGENCY

Name: _____

Phone - Home (___)-___-_____

Relationship: _____

BEST FORM OF CONTACT

☐ Home # ☐ Cell #

☐ Work # ☐ Email

GUARANTOR INFORMATION/LEGAL GUARDIAN

☐ Same as Patient

Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Gender: ☐ Female ☐ Male SSN ___-___-___ Marital Status S M D W (please circle one)

Address: _____ City: _____ State: _____ Zip: _____

Phone - Home (___)-___-_____ Work (___)-___-_____ Cell (___)-___-_____

Employer: _____ E-mail address: _____

RELEASE OF INFORMATION

I understand that should I choose to release my medical record to a specific entity and/or person(s), such as family members, I must specifically state so below in writing to be kept in my medical record. I also understand that should I want exceptions regarding the release of my records I must also state so in writing.

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone - Home (___)-___-_____ Exceptions: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone - Home (___)-___-_____ Exceptions: _____

We value your feedback! Let us know how we are doing at ***FeelBetterFaster.com***

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NOTICE: A COPY OF THE DETAILED OFFICE POLICIES AND HIPAA POLICIES ARE AVAILABLE AT THE FRONT DESK FOR REVIEW.

INSURANCE POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Insurance Release and Out of Network Policy. I hereby agree with and accept all terms.

PATIENT AGREEMENT & FINANCIAL POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Financial Policy and Patient Agreement. I hereby agree with and accept all terms.

CONFIDENTIALITY POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Confidentiality Policy. I hereby agree with and accept all terms.

MEDICAL RECORDS RELEASE POLICY: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Release of Medical Records Policy. I hereby agree with and accept all terms.

CONSENT FOR TREATMENT: By signing below, I acknowledge that I have been provided an opportunity to review TrustCare's Informed Consent. I hereby agree with and accept all terms.

HIPAA: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practice is available to me upon request and/or can be downloaded at ***FeelBetterFaster.com***. I understand that a copy of this consent form may be used with the same effectiveness as the original.

X _____ Date: ___/___/___
(Signature of patient or patient guardian)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I authorize the release of any information concerning my (or my child's) health care and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. We will file a claim with your insurance company for services provided. In the event of non-payment, you will be responsible for the charges incurred today.

X _____ Date: ___/___/___
(Signature of patient or patient guardian)

I have read the above statements and I understand the contents that I have read and agree to the terms thereof. I am also aware that a copy of all policies are available to me upon request or through our website: ***FeelBetterFaster.com***.

Print Patient Name _____ Date: ___/___/___

X _____ Relationship: _____
(Signature of patient or patient guardian)

Signature of Witness X _____ Date: ___/___/___

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