FLORIDA HEART ASSOCIATES

PATIENT DEMOGRAPHIC PROFILE

PATIENT ACCOUNT# _____

PATIENT'S NAME (Please Print)_____ SEX: M F AGE _____
BIRTHDATE _____ SSN _____MARITAL STATUS: S M W D SEP
LOCAL ADDRESS: _____TELEPHONE #:( ) ____- _____
CITY:_____, FL. ZIP CODE _____
EMPLOYER: _____WORK TELEPHONE # ( ) _____ - _____
SPOUSE'S NAME _____ BIRTHDATE _____ SSN# _____
SPOUSE'S EMPLOYER _____ _____SPOUSE'S WORK TEL # _____
E-MAIL_____ RACE_____ PRIMARY LANGUAGE_____

Part Time Residents Mailing Address
STREET_____
CITY: _____ STATE _____ ZIP CODE _____

Who referred you to our office? Family/friend_____ Doctor_____ Other_____

Reason for your referral: _____

(HMO Patient) Who is your local primary care doctor? _____

IN CASE OF EMERGENCY, PLEASE CALL: _____

RELATIONSHIP: _____ TELEPHONE # _____

Florida Heart Associates, P.L., participates in the provider networks of Medicare, and many major health plans. You are personally responsible for all co-payments, co-insurance and deductibles as defined by your plan coverage. These fees and charges for "non-covered" services are due and payable at the time of your appointment. Medicare enrollees may be required to sign an "ABN" (Advanced Beneficiary Notice) Form if applicable.

PRIMARY INSURANCE _____
POLICY HOLDER _____ ID # _____
SECONDARY INSURANCE _____
POLICY HOLDER _____ ID# _____

LIFETIME PRIMARY INSURANCE AND MEDICARE "B" SIGNATURE AUTHORIZATION

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL, OR OTHER PERTINENT INFORMATION ABOUT ME, TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, CENTERS FOR MEDICARE AND MEDICAID SERVICES, OR ITS INTERMEDIARIES OR CARRIERS, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE COMPANIES, OR THE BILLING AGENT OF FLORIDA HEART ASSOCIATES, ANY INFORMATION THAT IS REQUIRED FOR THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE ASSIGNED TO FLORIDA HEART ASSOCIATES, P.L.

MANAGED CARE AND HMO PATIENTS

I UNDERSTAND THAT PREAUTHORIZATION APPROVAL FOR EACH APPOINTMENT AND/OR PROCEDURE PRIOR TO A SCHEDULED APPOINTMENT MAY BE REQUIRED. WITHOUT PRIOR AUTHORIZATION, MY INSURANCE COMPANY MAY REFUSE PAYMENT OF CLAIM(S) AND I WILL BE PERONALLY RESPONSIBLE FOR PART, OR ALL OF, THE INCURRED BILL.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Rev 1/22/2015PE

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