HeartPLUS Diagnostic & Celestial Health Clinic

PATIENT REGISTRATION FORM

Demographics

Name: _____

Address: _____
(Street)

_____
(City) (State) (Zip)

Sex (circle one): MALE FEMALE DOB: _____/_____/_____

Social Security Number: _____

Status (circle one): MARRIED WIDOWED SINGLE LIFE-TIME PARTNER

Home: _____ Cell: _____ Work: _____

Email: _____

Insurance Carrier: _____/Number _____Primary

Insurance Carrier: _____/_____ Secondary

How did you hear about us?

Primary Care Physician

Name: _____

Address: _____
Street

_____
City State Zip

Telephone: _____

Patient's Name: _____

Patient's Signature: _____ Date: _____

CONSENT POLICY

Consent to Treat

I, the undersigned, hereby consent to and authorize the administration of all treatments, diagnostic testing, and therapies that may be considered advisable and/or necessary in the judgment of my Cardiologist.

This authorization shall remain in full force and effective for this and future outpatient visits.

Release of Medical Records

I authorize the release of my medical records to my physicians/primary care provider or other providers that are managing my care.

Photo Release

I hereby authorize HPC/CHC to take photographs of appropriate parts of my body to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and remain part of my medical record. I hereby authorize HPC/CHC to use photographs of me (no facial pictures), without identifying me, for educational and or publicly purposes.

Cooperation with Treatments

I understand for therapies, treatments, and etc., to be effective, I must come as schedule unless there are unusual circumstances that prevent me from attending therapies and appointments. If I have difficulty with any part of my treatment program, I will discuss it with my therapist and Cardiologist.

Therapy Only (Neuromuscular, Lymphedema, Medical Nutritional)

I understand if I am under therapy that my therapist will share with me her opinions regarding potential results of therapy treatment for my condition and will discuss all treatment options with me. I agree to cooperate with and carry out the home program assigned to me.

I WILL INFORM MY CARDIOLOGIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE AN EVALUATION OR TO BE TREATED. I HEREBY REQUEST AND CONSENT TO THE EVALUATION AND TREATMENT TO BE PROVIDED BY CARDIOLOGIST AND STAFF.

Patient's Name: _____

Patient's Signature: _____ **Date:**_____

PAYMENT POLICY

Cancellation and No-Show Policy

There is no fee if your appointment is changed or canceled 24 hours before the originally schedule appointment. Patients will be charge $35.00 for a no-show or cancellation made less than 24 hours before schedule time. After 2 no-shows in a row, Celestial Health will remove any future appointment scheduled. We believe communication is vital to a successful outcome and we will do everything possible to accommodate you.

Billing Policy

HPC/CHC is a medical insurance billable clinic but cash base option is accepted for those who insurance doesn't cover the procedures. HPC/CHC is committed to working with our patients to arrange acceptable payment options. We will offer payment plans with no interest. Please talk to our billing specialist. If no arrangements have been made, then monthly interest of 1.2% will be applied to the balance and sent to collection.

I have read and fully understand HPC/CHC'S financial responsibility. I acknowledge full financial responsibility for services rendered by Heartplus Diagnostic/ Celestial Health and its professional staff.

Patient's Name: _____

Patient's Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ (Signature of Patient or Authorized Representative) _____ (Date) _____ (Signature of witness) _____ (Date)

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual