Heart & Vascular
CENTER OF WEST TENNESSEE

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Patient Information

Patient Name: Last_____ First _____ Middle Initial_____
Preferred Name_____ Date of Birth_____ Sex_____
Address _____City_____State_____Zip_____
Phone Number_____ Cell Phone Number_____
Email _____ Social Security Number _____
Employer_____ Employer Phone _____
Employer Address_____
Martial Status: _____ Race: __ White __African American __Hispanic __ Other
Emergency Contact Name _____ Relationship to Patient_____
Phone Number_____ Alternate Phone_____

Responsible Party Information

Name Last _____ First_____ Middle Initial_____
Address_____ City_____ State_____ Zip_____
Date of Birth_____ Age_____ Sex_____ Martial Status_____ Social Security Number_____
Relationship to Patient_____ Home Phone_____ Work Phone_____

Employer_____ Employer's Address_____

Insurance Information

Are you covered by health insurance?_____ If no, please ask front desk staff about self pay options.

Primary Insurance _____ Policy Number_____ Group Number_____
Policy Holder Name_____ Policy Holder Date of Birth _____SSN_____

Secondary Insurance _____ Policy Number _____ Group Number_____
Policy Holder Name_____ Policy Holder Date of Birth _____SSN_____

Tertiary Insurance _____ Policy Number _____ Group Number_____

Consent for Payment

I hereby authorize payment of medical benefits billed to my insurance by Delta Clinics, PLC Providers. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time services rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Delta Clinics, PLC Providers do not participate in my insurance. I hereby authorize Delta Clinics, PLC Providers to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, Delta Clinics, PLC Providers can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that Delta Clinics, PLC Providers took before receiving my revocation.

Signature of Patient _____ Date_____

Printed Name of Patient_____ Relationship of representative to patient _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with a member of your family? YES NO

If YES, please name the member(s) allowed:_____

Family Member(s) Phone: _____

Please Verify/Update Your/Patient's Information Below:

Date of Birth:_____Cellphone:_____

Email:_____

Billing Address:_____

_____

Circle: YES or NO Occasionally Delta Clinics, PLC likes to take pictures and/or videos with staff and sometimes patients, *typically for fun or promotional events we do,* we may ask you to be part of our photos and/or videos with your permission.

This consent form is for the following: _____

(PRINT PATIENT'S NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____