SEVIER HEART CENTER
1240 Fox Meadows Boulevard, Sevierville, TN 37862

Date________________________

PATIENT INFORMATION

Name____
Last First Middle

Address____

City ____________________ State____________________ Zip ______________

Telephone: (Home)________________ (Cell)________________ Sex______ Marital Status______

Date of Birth ____________________ Social Security # ______________________

Employer (if minor, Guardian's employer) __________________________________

Employer Address ____

City ________________________ State ________________ Zip ______________

Work Phone ______________________ Occupation ________________________

Name of Emergency Contact **NOT LIVING WITH YOU** ________________________

Phone Number(s) ____

INSURANCE INFORMATION

Name of Policy Holder ____

Relationship to card holder: ☐ Self ☐ Spouse ☐ Other

If Spouse: ______________________ ______________________
Date of Birth Social Security Number

PLEASE GIVE THE RECEPTIONIST A COPY OF ALL OF YOUR INSURANCE CARDS

Primary Insurance Company ____

If you have Medicare: Supplemental/Secondary Insurance ______________________

If you have Medicare and are also covered under a spouse's commercial insurance, please indicate this.

Sevier Heart Center

LIVING WILL / POWER OF ATTORNEY

Do you have a Living Will?______________ Do you have a Power of Attorney?____________

If YES, please make sure we have a copy for your medical record.

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, billing problems or any other situation relating to your visit at our office. Please read and answer the following questions.

I give permission to this office to call the home number I've listed above and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.

Yes No

I give permission to this office to call the work number I've listed above and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.

Yes No

PRIVACY POLICY

I have received a copy of the Notice of Privacy Practices.

Yes No

GENERAL AUTHORIZATION

ASSUMPTION OF RESPONSIBILITY: The undersigned agrees, whether he signs as an agent or as a patient, that in consideration of services to be rendered to the patient named above he hereby obligates himself and agrees to pay upon demand to the above named Provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney fees and collection expenses. All delinquent accounts to bear interest at the legal rate. It is understood that bills are payable upon presentation.

ASSIGNMENT OF INSURANCE BENEFITS: I / We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment, and hereby assign any hospital insurance benefits, insurance sick benefits, or injury benefits payable because of liability of a third party payable to or for the above said patient unless accounts for said patient have been paid in full.

AUTHORIZATION TO RELEASE INFORMATION:

I/We hereby agree that the above named Provider may release the Patient's health information as follows:

- To the Patient's insurance company or companies;
- To the Patient's family, friends or others involved with the Patient's care;
- To the Provider's employer, agent or other third party acting either on behalf of the Provider or pursuant to an agreement with the Provider;
- As necessary for research purposes described in the Notice of Privacy Practices;
- To the Patient's employer if the Provider provides health care to the Patient at the request of the employer to conduct an evaluation relating to medical surveillance of the workplace or to determine whether the Patient has a work-related illness or injury, provided that the employer needs the information to comply with certain laws regarding workplace safety. Such information will be limited to findings concerning a work-related illness or injury or workplace-related medical surveillance;
- For the specialized government functions described in the Notice of Privacy Practices;
- To funeral directors, coroners, or medical examiners as necessary to perform their functions; and to organ procurement organizations.

Signed: ______________________________________ Date: ________________________