Georgia Heart Physicians, LLC

654 First Street	105 Avera Dr.	235 Margie Dr. Suite 300	540 West Thomas St Ste E
Macon, GA. 31201	Fort Valley, GA. 31030	Warner Robins, GA. 31088	Milledgeville, GA. 31061
(478) 738-9443	(478) 827-1444	(478) 333-6167	(478) 453-8991
(478) 738-9750	(478) 827-1005	(478) 333-6288	(478) 454-0041

Date: _____ Referred By: _____

Patient's Name: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Cell ( ) _____

Date of Birth _____ SSN: _____- _____- _____ Sex: ____

Pharmacy Name: _____ City: _____

Do you have a living will: Circle one **Yes** or **No?**

Employer _____ Phone ( ) _____

Spouse: _____ Phone ( ) _____

Work number ( )_____ Employer _____

Email address: _____@_____

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PLEASE PRESENT YOUR INSURANCE CARD(S) AND I.D. TO THE RECEPTIONIST

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EMERGENCY CONTACT INFORMATION:

Name: _____ Phone _____ Relationship_____

Name: _____ Phone _____ Relationship_____

I certify that the information given above by me is correct. I hereby authorize the release of any medical information to my insurance company to be used by them in consideration for payment of any claims resulting from my treatment. I will not hold this health care entity or its providers responsible for any further dissemination of my medical information by my insurance (s). I authorize this facility and its professional staff to provide treatment as indicate form my medical condition. I hereby assign to the physicians, all medical benefits payable for the services rendered. I authorize the use of this signature on my insurances submission. A copy of this authorization may be used in place of the original.

_____

Signature Date

I request that payment of authorized Medicare benefits be made on my behalf to Georgia Heart Physicians, LLC for any services furnished to me by any physician at this practice. I authorize any holder of medical information about me to be released to the Health Care Financing administration or its agents. Any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurances are indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carried as the full charge and the patient is responsible only for the deductible, coinsurances and determination of the Medicare carrier

_____

Signature Date