



HEART 2 HEART CARE CLINIC, LLC

1984 Wooddale Blvd, Baton Rouge, La, 70806

OFFICE: 225-300-6010

FAX: 225-206-8683

Website: www.h2hccmed.com

Patient Demographic Form

Last Name: _____ First name: _____ MI: _____

DOB: _____ SS #: _____ Sex: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ @ _____ Referred by: _____

Primary Care Physician Name and Phone:

Pharmacy Name and Phone No.:

Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Ins Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policyholder DOB: _____ Policy holder address: _____

Policyholder SS #: _____ Policyholder Sex: _____ Copay Amount: _____



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Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____

Date _____

Managed Care / HMO - Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

Have you ever been diagnosed or treated for the following? (if yes, please specify)

Yes or No Heart Disease?

Yes or No High blood pressure?

Yes or No Lung Cancer?

Yes or No Cancer?



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Yes or No Diabetes?

Yes or No Thyroid disease?

Yes or No Kidney disease?

Yes or No Gastrointestinal disease? (Stomach, colon, liver, etc) _

Yes or No Infectious diseases? (Hepatitis, T.B., AIDS, HIV, Lyme, etc..)

Yes or No Major Surgery?

Yes or No Difficulty with healing wounds?

Yes or No Any keloids, bad scars or excessive bleeding?

Do you have a history of:

Asthma? Yes ___ No ___

Hives? Yes ___ No ___

Eczema? Yes ___ No ___

Psoriasis? Yes ___ No ___

Skin cancer? Yes ___ No ___

Other skin disorders? Yes ___

No ___



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Are you allergic to any medications? (if so, please list)

Are you taking any medications including vitamins and supplements? (if so, please list) _____

Are you pregnant or nursing? (if applicable)

Do you have a need for antibiotics prior to surgery or visiting the dentist?

When was your
last:

Colonoscopy:

PAP Exam:

Mammogram:

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____ **Date:** _____

Relationship to Patient (if applicable): _____



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HIPPA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (printed): _____

Signature: _____ **Date:** _____

Relationship to Patient (if minor): _____



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Consent for Evaluation and/or Treatment

By signing below, I am giving my consent to the practice of **SHETILA BURRELL, MSN,FNP-C** for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline. I understand that regardless of the outcome of my provider visit I am responsible and hereby required by my insurance carrier to pay my obligated copay at the initiation of each visit.

Patient Name (printed):

Signature: _____ **Date:** _____

Relationship to Patient (if minor): _____

(Revised
02/2020)



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Contact Information

May we leave a message concerning your test results.....

On your answering machine/voicemail?

Text Message? _____

With another Person? _____

Please list the person(s) with whom we can discuss your protected health information?

Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. **We require notice of cancellations by 0800 the day of the visit.** As a courtesy, reminder calls are made 1-2 days before your appointment to allow for you to contact us in the event you need to cancel or reschedule your appointment. We ask that you provide us with the same courtesy. If an appointment is missed, cancelled or rescheduled without notice there will be a \$25.00 charge billed to the patient. By signing below I am acknowledging that I have been notified of the cancellation policy.

Patient Signature: _____ **Date:** _____

Parent/Guardian Sig. (if applicable): _____ **Date:** _____

Relationship to Patient (if applicable): _____