NAME OF REFERRING DOCTOR_____ DATE_____

PATIENT	SS NUMBER	MARITAL STATUS					SEX		BIRTHDATE
		S	M	W	D	SEP	M	F	

RACE (Choose One)

American Indian or Alaska native___ Asian___ Black or African American___

Other race___ Native Hawaiian or other Pacific islander___ White___ Unknown___

ETHNICITY (Choose One)

Not Hispanic or Latino___

Hispanic or Latino___

E-MAIL ADDRESS:_____

PHYSICAL ADDRESS	CITY, STATE and ZIP CODE	HOME PH. #

MAILING ADDRESS	CITY, STATE and ZIP CODE	CELL #

PATIENT OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUS. PH. #

EMPLOYER'S STREET ADDRESS	CITY, STATE and ZIP CODE	E-mail address

SPOUSE OR PARENT'S NAME	SS NUMBER	BIRTH DATE

SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUS. PH. #

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

NEXT OF KIN	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PH. #

It is understood that no oral or written contract exists which designates by name or description, the individuals who will treat the patient. The individual who treats the patient may vary from time to time due to emergencies of the location at which the patient wishes to be seen. We will make every effort for you to be seen by the physician of your choice, but appreciate your understanding when it is not possible.

I hereby authorize Jackson Heart Clinic to administer treatment and perform necessary procedures in diagnosing and/or treating my condition. Also, I hereby authorize the release of any medical information necessary for the processing of insurance. This assignment will remain in effect until revolved by me in writing. This assignment is to be considered as valid as an original.

_____

Signature of Patient Date

As a service to our patients, we will assist you in filing your insurance and assist you in obtaining reimbursement. However, all charges incurred remain the responsibility of the patient.

I agree to pay all cost of collection, including a reasonable attorney's fee.

_____

Signature of Patient Date

Acknowledgement of Receipt of Notice of Privacy Practices

Jackson Heart Clinic, P.A.

I hereby acknowledge that I have received and reviewed a copy of Jackson Heart Clinic's Notice of Privacy Practices.

PatientName(print):_____ **Date:**_____

Patient Signature:_____ **Telephone:**_____

If not signed by the patient, please indicate relationship:

- ◯ Parent or Guardian of minor patient
- ◯ Guardian or Conservator of an incompetent patient
- ◯ Beneficiary or personal representative of deceased patient
- ◯ Other (specify) _____