Patient Registration and Authorization

Patient Information:

First Name: ______________ Last Name: ______________ Middle Initial: ______

Preferred Name: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Home Phone: __________ Work Phone: __________ Cell Phone: ______________

Sex (Select one): Female Male

Date of Birth: ______________ Social Security Number: ______________

Email: ______________________________

Relationship to Insured (Select one): Self Spouse Child

Responsible Party Information:

First Name: ______________ Last Name: ______________ Middle Initial: ______

Home Phone: __________ Work Phone: __________ Cell Phone: ______________

Date of Birth: ______________ Social Security Number: ______________

Address (If different from above): ______________________________

City: ______________ State: __________ Zip: __________

Primary Insurance Information: COPY OF CARD REQUIRED AT TIME OF SERVICE

Name of Policy Holder: ______________________________

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Financial Agreement

If the patient does not have insurance or is requesting to waive insurance filing, full payment is expected at the time of service unless other arrangements have been made prior to the date of the appointment. Insurance can only be ran with a physician's order, testing performed without will require upfront payment.

Insurance companies pay benefits based on fees that they determine according to contracts negotiated with employers. Insurance is designed to help patient s pay for the care they need. Please understand insurance may not pay for the entire fee and in some cases may not cover the service at all. If this should occur, the patient or their responsible party is liable for the balance not covered by insurance. Our goal is to provide the best possible care to our patients, and to do this we cannot let any insurance company dictate those guidelines. Patients who have insurance should remember that professional services are provided and charged to the patient or their responsible party, not the insurance company. We will bill for any balances after insurance is ran.

Sixty days will be allowed for the patient's insurance company to process the claim. If, after sixty days, no notice has been received from the insurance company, the responsible party will be required to contact them directly and payment is due in full at this time. Late payments will be subject to a charge of 12% APR. Please note a $35.00 fee will be assessed for all returned checks. A 5% fee will be assessed for the use of credit cards. If any balance is overdue and legal and/or collection assistance becomes necessary, the responsible party will be liable for charges incurred. I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I give Heartland Health Laboratories, Inc. permission to release any necessary records to my insurance company or companies as needed.

This signature is on file as my authorization for the release of information necessary to process my claim. I hereby authorize payment to Heartland Health Laboratories, Inc. of the insurance benefits otherwise due me.

I have read the above financial policy and agree to the terms outlined within.

Printed Patient Name: ______________________________

Patient Signature ______________________________ Date: ____________

Patient Result Request

I understand the results of my testing will be sent directly to the ordering physician. I do have the right to also request my results be sent to me directly. If requested, results will be sent via the below contact method(s).

ONLY COMPLETE IF A COPY OF RESULTS ARE NEEDED BY PATIENT (if patient will get result(s) from ordering physician please cross out):

Secure Fax: ______________________________

Email: ______________________________