Heart Squad

PATIENT ENROLLMENT FORM

Start Date _____ End Date _____ Follow up Appointment_____

PATIENT INFORMATION:

Name: Last _____First_____M_____F_____

DOB_____ SS #_____

Address: _____City_____St_____

Zip_____ Cell Phone#_____

Email_____

INSURANCE: *PLEASE ATTACH COPY OF INSURANCE CARD*

PRIMARY: _____ Phone# (_____)_____

ID# _____ Group # _____

Insured's Name: _____ Insureds DOB_____

SECONDARY:_____ Phone# (_____)_____

Insured's Name: _____ Insureds DOB_____

ORDER: Heart Phone Monitor

INDICATIONS: (For reimbursement at least one must be checked)

	Atrial Fibrillation 427.31		Premature Beats (Unspecified) 427.60
	Atrial Flutter 427.32		Syncope 780.2
	Chest Pain 786.50		Tachycardia-Sinus 427.1
	Chest Tightness/Discomfort 786.59		Tachycardia, Supraventricular-Atrial 427.0
	Conduction Disorder (Unspecified) 428.9		Tachycardia-Ventricular 427.1
	Dizziness 780.4		Arrhythmia (unspecified) 427.9
	Palpitations 785.1		

I hereby authorize (Write Insurance Company Name) _____ to make payment directly to Heart Squad, Inc. I also agree to assume financial liability if the insurance carrier denies payment for services rendered.

Patients Signature: _____ Date:_____

I hereby attest that this test is medically necessary.

Doctor's Name:_____ Signature: _____

Email for ECG: _____ Phone#:_____