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		Premature Beats
	Atrial Flutter		Syncope
	Chest Pain		Tachycardia-Sinus
	Chest Tightness/Discomfort		Tachycardia, Supraventricular-Atrial
	Conduction Disorder (Unspecified)		Tachycardia-Ventricular
	Dizziness		Arrhythmia
	Palpitations		_____

I hereby authorize (Write Insurance Company Name) _____ to make payment directly to Heart Squad, Inc. I also agree to assume financial liability of $99 for the Heart Phone and $10 per ECG diagnosed 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#:_____

PLEASE SEND THIS FORM AND A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD, TO HEART SQUAD

1601 N. SEPULVEDA BLVD #216, MANHATTAN BEACH, CA 90266 CONTACTUS@HEARTSQUAD.COM PHONE: 310-939-7654