

# Heart Squad

## ECG MONITORING

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:** Monthly ECG Monitoring

**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 ECG Monitor 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**