HEARTFIT FOR DUTY

*Protecting Our First Responders*

| How did you hear about us? | Today's Date: |
|---|---|

| **Patient Information** | | | |
|---|---|---|---|
| Last Name: | First Name: | | M.I.: |
| DOB: | | SSN: | |
| Age: | | Gender: | |
| Phone: | | Other Phone: | |
| Email: | | Married: ☑ Yes | ☑ No |
| Address: | | City: | |
| State: | | Zip: | |
| Employer: | | City: | |
| Occupation: | | | |

| **Emergency Contact/ Parent/ Guardian/ Spouse** | |
|---|---|
| Last Name: | First Name: |
| Home Phone: | Cell Phone: |
| Relationship: | Other: |
| Other: | Ok to Discuss Labs or Reports: Yes ☐ No ☐ |

| **Primary Insurance** | |
|---|---|
| Policy Company: | ID#: |
| Policy Address: | Group#: |
| Policy City: | Policy Holder: |
| Policy Zip: | Relationship: |

| **Secondary Insurance** | |
|---|---|
| Policy Company: | ID#: |
| Policy Address: | Group#: |

| | |
|---|---|
| Policy City: | Policy Holder: |
| Policy Zip: | Relationship: |

# Signed Documents

## AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all charges submitted by this office during the treatment for the patient. I agree to pay all applicable co-payments, co-insurance, and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third-party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours' notice to HeartFit For Duty when cancelling an appointment, I may be responsible for charges up to the potential cost of the visit.

### RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize HeartFit For Duty and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, and other healthcare providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request the payment of any third party or insurance company benefits be made directly to HeartFit for Duty for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

### FINANCIAL POLICIES

Thank you for choosing to seek services with HeartFit For Duty. We are committed to providing excellent healthcare services to our patients. As part of our professional relationship it is important that you understand our financial policy.

It is your responsibility to provide us with your most current insurance and billing information. Co-payments, co-insurance, and deductibles are due at the time of service. For co-insurance and deductibles, we will estimate the amount you owe. You will be responsible for the balance after your insurance company pays your claim.

We accept cash, checks, Visa and Mastercard. You will receive a statement from our billing office for any balance due. Payment for your balance will be due upon receipt of the statement. If you are unable to pay the balance in full, you must contact our office to make payment arrangements.

****IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS****

If we are the preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect the information you provide. However, the agreement of the insurance company to pay for medical care is between you and the carrier.

Please present your card with each visit.

If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen.

Delinquent accounts over 60-days shall be sent to collections for processing, at which all collection fees, contingent or not, shall be added to the patient's responsibility. In the event, legal action is required, the patient shall be responsible for all reasonable attorney's fees and costs.

If your check is returned due to insufficient funds you will be charged an additional $35.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

## CONFIDENTIALITY

In order to receive the course of evaluation and treatment offered by HeartFit For Duty, the Patient will be exposed to certain information about the processes, testing, and strategies implemented by HeartFit For Duty. The company considers such information to be proprietary and confidential and is willing to evaluate, treat, and disclose such information to the Patient, only upon receipt of the agreement of the Patient to comply with the provisions hereof. "Confidential Information" shall mean all information about HeartFit For Duty which is furnished by it or any of its representatives to Patient, and includes, without limitation, all information regarding the business and affairs of HeartFit For Duty, its operations, testing processes, analytical methods, business partners, media and/or presentations, educational or informational material, analyses, compilations, forecasts, studies, procedures, formulae, improvements, trade secrets or other proprietary documents or information prepared or furnished by HeartFit For Duty, that has been previously or may hereafter be disclosed in any form, whether in writing, orally, electronically, or otherwise, made available by observation, inspection, or otherwise by the HeartFit for Duty, or its affiliates or representatives. Confidential Information shall not include test results, medical reports or records generated by HeartFit For Duty which are personal to the Patient and which would normally be used in Patient's further health evaluations and treatment.

Unless otherwise agreed to in writing by HeartFit for Duty, the patient agrees to keep confidential all Confidential Information and not to disclose or reveal any Confidential Information to any person other than Patient's personal physician(s) or doctor(s) for the sole purpose of Patient's further health evaluations and treatment. Patient further agrees not to use Confidential Information for any purpose other than in connection with Patient's further health evaluations and treatment, including without limitation, to engage or participate, or aid another in engaging or participating, in any venture or business which would directly or indirectly compete with the services offered by HeartFit For Duty in the normal course of business.

**I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES AND I AGREE TO ABIDE BY ALL TERMS.**

| | | | |
|---|---|---|---|
| Patient Signature | | Date | |

# Patient Informed LAB Consent
# PLEASE READ

I, _____(Patient' s Name) authorize HeartFit For Duty to conduct **LAB TESTING to include but limited to, Cardio IQ, Omega and NPO panels and Vitamin D**, as ordered by my physician or authorized healthcare provider or my child's or dependent's physician or authorized healthcare provider, and authorize the collection of a sample for the purpose of that testing.

**I acknowledge and consent to the following:**

1. My physician or his/her designee has fully covered the following: (a) purpose, description and nature of the test and its potential uses; (b) description of the disease or condition tested for.

2. I understand that the received tests might **NOT** be covered under my insurance, some insurance companies consider these tests investigational and **DO NOT COVER** the expense.

3. These tests are **not included** in an Annual Wellness blood panel; they are **not covered** 100%. Your insurance benefits will apply if covered under your insurance, including a coinsurance and deductible.

4. You will **likely receive a bill** from Sonora Quest for these tests.

5. I understand that I will receive the tests from my physician unless I direct otherwise. I understand that l have a right to confidential treatment of my sample and results and that my test results will only be disclosed as authorized in this consent.

**Patient's Statement**

I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks, and I have received a copy of this consent. l have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time.

**Signature of Patient** **Date**

**Signature of parent or legally authorized representative** **Date**

**HeartFit For Duty LLC**
1901 E University Ave, Ste #200, Mesa, AZ, 85203
Phone:480-999-7911 Fax: 480-499-5829
www.heartfitforduty.org

**Printed Name of Parent or Legally Authorized Representative Relationship to Patient**

## General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

**Signature of Patient**

**Printed Name of Patient** **Date**

## ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, _____ , agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement. I further agree my signature on this document is as valid as if I signed the document in writing. This is to be used in conjunction with the use of electronic signatures on all forms regarding any and all future documentation with a signature requirement, should I elect to have signed electronically. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

Signature: _____ Date: _____

# Nutrition Questionnaire

**Name:**_____ **Date:**_____

Filling out this questionnaire will help give us a basic understanding of your eating habits. A basic nutrition consult is included as part of your first visit, because here at HeartFit we are about HOLISTIC health, not just one small piece of the puzzle. If you would like further nutrition coaching after your initial visit, please don't hesitate to make a nutrition appointment.

**Please answer the following questions:**

**1. What type of eating style/diet do you currently follow? Check all that apply.**

- ☐ Low-carb
- ☐ Low-fat/calorie
- ☐ Vegan/vegetarian
- ☐ Keto
- ☐ Gluten-free
- ☐ Dairy-free
- ☐ Paleo
- ☐ Other_____

**2. How *many times* do you usually eat in a day? (meals + snacks)**

- ☐ 1-2
- ☐ 3-4
- ☐ 5+

**3. How *often* do you eat on a given day?**

- ☐ Every 1-2 hours
- ☐ Every 3-4 hours
- ☐ Every 4-6 hours
- ☐ Over 6 hours

**4. How many/much of each beverage do you drink in a typical day:**

- ☐ Water:_____
- ☐ Coffee:_____
- ☐ Sports drinks:_____
- ☐ Soda:_____
- ☐ Tea:_____
- ☐ Energy drinks:_____
- ☐ Juice:_____
- ☐ Milk:_____
- ☐ Alcohol: _____

If yes to alcohol, please explain what type:

_____

**5. Do you eat out more than 3x per week?**

- ☐ Yes
- ☐ No

**6. Is there anything you'd like to change about your diet or eating habits?**

- ☐ Yes
- ☐ No

If yes, please explain:

_____

**7. Who cooks most often in your home?**

- ☐ Spouse/partner
- ☐ Myself
- ☐ Other

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