HEARTFIT FOR DUTY

Protecting our First Responders

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

Patient Information					
Last Name		First Name		M.I.	
Date of Birth				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:

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

Revision Completed 09/21

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****

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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	

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Authorization to Use and Disclose Health Information

I _____ understand that under HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearance house involved in my insurance claim fulfillment.

Under HIPAA regulations, the following people must be authorized to have access to my health insurance information (for example: Spouse, other family members, friends, life partners, nurse or home health aide, or any other person not involved in your medical treatment, insurance plan or payment)

Name: _____
Phone: _____
Address: _____
_____
Relationship:_____

Name: _____
Phone: _____
Address: _____
_____
Relationship: _____

Are there limitations on what information can be disclosed- Yes No
If yes, what do you wish to release: _____

Is there a date that this person's authorization will expire- Yes No
If Yes, what date will this authorization expire? _____

I understand that I may revoke this authorization at any time by giving written notice to HeartFit For Duty, LLC.

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of HeartFit For Duty, LLC who are part of my healthcare process. These business associates will also keep your health information confidential.

By signing this document, I understand and authorize HeartFit For Duty to contact me at the telephone number or email that I have provided. I understand and Authorize HeartFit For Duty, LLC to leave messages on this number and any pertinent information which may be relative to my care.

_____ _____
Patient Signature **Date**

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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 recommend 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 _____

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Authorization to Receive Medical Records

I authorize the release of my entire medical records by the organization or physician listed below:

PREVIOUS PHYSICIAN INFORMATION

Physician Name		**Practice**	
Phone #		**Fax#**	

PATIENT INFORMATION

Patient Name		**DOB**	
Phone #		**SSN#**	

PLEASE FAX ENTIRE MEDICAL RECORDS TO: 855-372-1670

Disclaimer:
The medical records or medical information are requested for the purpose of continuing my medical care and treatment. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present any written revocation to the medical records department. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless I specify differently, this authorization will expire six-months from the date signed below. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the information may not be protected by federal privacy laws or regulations. I understand that the use or disclosure if the information identified above is voluntary, I need not sign this form to insure healthcare treatment.

HIV/AIDS:	I consent to the release of any positive or negative test results of AIDS or HIV infection, antibodies to HIV/AIDS, or infection with any other causative agent of AIDS with the rest of my medical record.	☐ Yes ☐ No

Patient Signature		**Date**	
Legal Representative		**Relationship**	

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Nutrition Questionnaire

Name:_____ Date: _____

Introduction: Your eating habits affect more than the number on the scale and your appearance; they affect the chemicals in your brain, your mood, your energy levels, your digestion and your overall health. What you eat can put you at risk for chronic health conditions and diseases. When and what you eat is complicated and can be influenced by psychological, social and genetic factors - every person is unique with bio-individualities. Understanding basic nutrition principles is the first step to preventing chronic conditions such as diabetes, obesity and cardiovascular disease. "Let food be thy medicine and medicine be thy food." -Hippocrates

Filling out this questionnaire will help give me 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. Do you follow a specific diet or eating style?

Yes No No, but I have in the past

2. What kind of eating style/diet do you follow? (Circle all that apply)

Low-carb Low-fat Low-calorie

Vegan/vegetarian Keto Diabetic

None Other:_____

3. How many meals do you usually eat in a day?

1 2 3

4. How many snacks do you usually eat in a day?

None 1 2 >2

5. Do you often skip meals? (Circle all that apply)

Breakfast Lunch Dinner None

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

Water:_____ Coffee:_____ Sports drinks:_____

Soda:_____ Tea:_____ Energy drinks:_____

Juice:_____ Milk:_____ Alcohol:_____

7. How many days per week do you eat meat?

1-3 days per week 4-6 days per week Every day Never

8. What kind of meats do you eat on a regular basis? (Circle all that apply)

Beef Chicken Pork Turkey

Fish Bacon Sausage Deli/lunch meats

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9. How often do you eat out in a week?

Rarely/Almost never | 1-3 times per week | 4-6 times per week | Daily

10. When you eat out, where do you usually go? (List the top 2-3 places)

_____

11. Who does the grocery shopping in your home?

Spouse/significant other | Myself | Child/children

Other:_____

12. Who cooks most often in your home?

Spouse/significant other | Myself | Child/children

Other:_____

13. How often do you eat sweets or dessert?

Daily | Occasionally | Only on special occasions/holidays | Never

14. What is the hardest for you to resist?

Sweets (donuts, cookies, candy) | Snacks (chips, pretzels) | Savory foods (pizza, wings, burgers) | Soda or sweetened beverages (juice, Starbucks) | Alcohol

15. Do you think you eat proper portions or the right amount of food each day?

Yes | No, too much | No, not enough

16. Are you satisfied with your eating patterns?

Yes | No

17. If not, what would you like to change? (Circle all that apply)

Type of foods | Amount of foods | More vegetables | Less junk food or sweets | More water

Other: _____

18. Why do you want to change your eating habits? (Circle all that apply)

I don't | To lose weight | To get fit/look good

Diabetic | To have more energy | To be healthier/for overall wellness

High blood pressure | To feel better | Other:_____

19. If we had ready-to-eat meals for purchase at HeartFit, would you be interested in purchasing them? (i.e. meat & veggies, egg bites, etc.)

Yes | No

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