Our team of cardiologists, nurses, technicians, and staff look forward to your visit. Fort Worth Heart is proud to offer state-of-the-art diagnostic methods and individual attention to patient needs.

Scheduling Your Appointment

To schedule your appointment, or if you must cancel an appointment, please call (817) 338-1300.

Your appointment may include one or more diagnostic tests used to determine how your heart is functioning. Due to the comprehensive exam that will be done, and the possible need for diagnostic testing, you should wear comfortable clothing and shoes. Additionally, to help our cardiologists develop a treatment plan that is best for you, it is necessary that you bring all of your current medications with you to every visit.

On occasion, our doctors become involved in unscheduled emergencies away from the office. If this should occur during your appointment time, every effort will be made to accommodate your needs. Depending upon the nature of the emergency, you may be asked to wait for the physician to return, to reschedule your appointment for another day in the near future, or to see another physician at Fort Worth Heart.

Your Appointment

On the day of your appointment, please:
-Bring all medications that you are currently taking
-Wear comfortable clothing and walking shoes
-Bring necessary insurance forms and a current insurance identification card if applicable
-Bring a referral letter if required by your insurance carrier or HMO
-Be prepared to supply insurance co-payment for services rendered
-Bring studies or reports performed by your referring physician

Payment Policy

As a courtesy to our patients, Fort Worth Heart provides insurance billing services. It is important that patients understand that insurance coverage varies greatly, depending upon the type of policy. Insurance benefits rarely cover the entire cost of a patient's visit. We expect our patients to pay all uncovered costs incurred under our care. We thank you for your cooperation in this matter.

If your insurance carrier requests a referral letter from your primary care physician, it must be presented to the receptionist upon your arrival. Your insurance carrier will not honor a claim unless these steps are followed. Failure to secure such a letter will result in greater uncovered costs and larger out of pocket expenses for you.

If you do not have health insurance, please contact our billing office prior to your appointment to arrange payment options.

Patient Information

Cardiologist:______________________________
Date: ______________________________

Personal Information

Name ____
First *Middle* *Last* *E-Mail Address*

Address ____

____
City *State* *Zip*

Home Phone ____________ Cell Phone ____________ Male ______ Female ______

SS# ____________ DOB ____________ Marital Status ____________

Employer ____

Employer Address ____

____
City *State* *Zip*

Employer Phone ____________ Occupation ____________

Nearest Relative Not Living with You ____________ Relationship ____________

Address ____

____
City *State* *Zip* Phone ____________

Spouse Information (or Parent/Guardian if Patient is a Minor)

Name ____________ Date of Birth ____________ Cell Phone ____________

SS# ____________ Employer ____________

Employer Address ____

Phone ____________ Occupation ____________

Family Doctor

Name ______________________ Phone ______________________

Insurance Information

Insurance Company ____________ Group/Policy # ____________ ID# ____________

Name of Insured ____________ Relationship to Patient ____________

Insured's Employer ____

Insurance Company Phone ____

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Fort Worth Heart, PA, or on its premises, including physician services. I authorize any holder of information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or other benefits related to these services. I appoint FWH to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

Signature of Patient______________________________ Date______________________

I request that payment by ______________________________ of any and all medical and/or surgical benefits to which I am entitled through private insurance or any health plans, including major medical benefits, be made to: Fort Worth Heart, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient ______________________________ Date______________________

Fort Worth Heart PA

Fort Worth Heart, PA including physicians and staff, provides cardiac care *only*. We do not provide any general medical or non-cardiology care or checkups. We therefore require all of our patients to have a primary care physician (internal medicine, family practice, general practice, etc.).

Fort Worth Heart, PA considers it to be your responsibility to have a primary care physician and to have your health care provided and monitored under their direction, as we do not provide those services.

I acknowledge that I have read and understand the above.

Printed Name	Signature
Date	Date of Birth

La clinica Fort Worth Heart, PA incluyendo medicos y empleados, se limita al cuidado intensive para el Corazon. No proveemos cuidados de medicina general, o cuidados que no sean para el Corazon o revisions rutinarias. Por lo tanto nosotros pedimose que todos nuestros pacientes tengan us doctor de cabecera (medicina interna, practica familiar, medicina general).

La clinica Fort Worth Heart, PA considera que es bajo su responsabilidad tener un doctor de cabecera para el cuidado de salud y bajo el direccion de el orella mantener su cuidado de salud, ya que nosotros no ofrecemos esos servicios.

Yo reconozco que he leido y he entendido la parte superior.

Nombre	Fecha
Firma	Fecha de nacimiento

Fort Worth Heart, PA

Acknowledgement of Privacy Notice

Patient Name:____

Date of Birth: ____

Social Security Number: ____

I acknowledge that Fort Worth Heart provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____

Patient Signature

____

Date

____

Personal Representative Signature (if applicable)

____

Relationship to Patient

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient annually.

Patient Name:____

Date of Birth: ____

I authorize Fort Worth Heart, PA to release my medical information as necessary to process my medical claim and coordinate or manage my healthcare. I understand that my medical information will be available to my treating physicians electronically via a secure health information exchange.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation or treatment, I give Fort Worth Heart, PA and its physicians, or employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

		May we leave a message at this number regarding appointments, test results, prescriptions, etc.?	
Home Phone:	____________________	**YES**	**NO**
Office Phone:	____________________	**YES**	**NO**
Cell Phone:	____________________	**YES**	**NO**

With whom may we discuss or release information about care, treatment, or diagnosis?

Name	**Relationship**	**Phone Number**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

______________________________________ ______________________________________

Signature (*valid one year from date)* Date

____

Witness