Brazos Heart Rhythm
Complex Arrhythmia Specialists

REFERRED BY (if applicable):_____

PERSONAL INFORMATION

Name:	**Sex: ☐ M ☐ F**	**Date of Birth:**
Social Security No.:	**Marital Status: ☐ S ☐ M ☐ D ☐ W**	
Billing Address:	City/State/Zip:	
Other Address:	City/State/Zip:	
Home No.: ( )	Mobile No.: ( )	
Email:		

EMERGENCY CONTACT

Name:	Relationship:	Phone: ( )

PHYSICIAN INFORMATION

Primary Care Physician:	Phone: ( )
General Cardiologist:	Phone: ( )

RESPONSIBLE PARTY INFORMATION (If over 18, go to next section)

Name:	Relationship:	Phone: ( )

INSURANCE INFORMATION *(INSURANCE CARD REQUIRED AT TIME OF SERVICE)*

Primary Insurance Co.:	**Secondary** Insurance Co.:
I.D.:	I.D.:
Group No.:	Group No.:
Effective Date:	Effective Date:
Claims Address (on back of card):	Claims Address (on back of card):
Policy Holder's Information Only Below This Line	***Policy Holder's Information Only Below This Line***
Name:	**Name:**
Social Security No.:	**Social Security No.:**
Date of Birth:	**Date of Birth:**
Relation to insured: ☐ Self ☐ I am the spouse ☐ I am a child/dependent ☐ I am an employee ☐ I am the significant other ☐ Other: _____	**Relation to insured:** ☐ Self ☐ I am the spouse ☐ I am a child/dependent ☐ I am an employee ☐ I am the significant other ☐ Other: _____

Release: I, the undersigned, understand that I am financially responsible for any amount not covered by my health insurance provider. I also authorize the practice to release my insurance company or their agent, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Brazos EP PLLC DBA Brazos Heart Rhythm. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information to secure payment.

I understand that by providing my email I consent to receive messages from Brazos Heart Rhythm.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURANCE, OR OTHER BALANCE NOT PAID OR COVERED BY MY INSURANCE COMPANY AT THE TIME SERVICES ARE RENDERED.

I also hereby acknowledge that I have received and reviewed the Privacy Notice of Brazos Heart Rhythm.

SIGNED: _____**DATE:**_____/_____/_____

Patient; Parent or Guardian Signature (if patient is under 18 years old)