Patient Information

Your Name: ____ Birth Date: ____________________
(First) (MI) (Last)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____________

Address: _________________________________ City: _______________State: ______ Zip: _________

Primary Phone: __________________________ Secondary Phone: _____________________________

Gender: ☐Male ☐ Female Social Security #: _____________________________________

Referring Physician: _________________________ Primary Care Physician______________________

Optional Questions

Preferred Language:______________ Race: ☐American Indian/Native Alaskan ☐ Black/African American ☐Asian ☐Native Hawaiian/Pacific Islander ☐White ☐ Hispanic/Latino ☐Other

Responsible Party

Name: _______________________________ Address: ______________________________________

City: _________________ State: ______ Zip: _______________ Phone: _________________________

Emergency Contact ☐ I authorize HeartCare Associates of AZ to release health information to my Emergency Contact

Name: _____________________________ Relationship: _____________ Phone: __________________

Additional Information

Occupation: __________________________________ Employer: ____________________________

How did you hear about us? ☐Friend/Family ☐Our Website ☐Other Website ☐Primary Care Physician ☐Social Media ☐Radio ☐ Magazine/Other Publication ☐Online Review/Rating Site

Insurance Information

Primary Insurance Company: __________________________________ Relation to Subscriber ________

ID#: ____________________________________ Group #: ____________________________________

Subscriber Name: _______________________ Birth Date:____________ SSN ____________________

Secondary Insurance Company: ________________________________ Relation to Subscriber ________

ID#: ____________________________________ Group #: ____________________________________

Subscriber Name: _______________________ Birth Date:____________ SSN ____________________

______☐ **AUTHORIZATION**: I assign all medical/surgical benefits to and understand if eligibility of insurance cannot be verified or if deductible has not been met, I will be responsible for the cost of all medical services rendered. I hereby authorize payment directly to Heart One Associates for the surgical and and/or medical benefits, if any, otherwise payable under terms of my insurance.

______☐ **PATIENT WAIVER**: I hereby authorize Heart One to release any information acquired in the course of my examination or treatment. I hereby authorize the physician, hospital, or medical facility to provide all information on my medical history and treatment to Heart OneAssociates. I hereby authorize photocopies of this form and my signature to be as valid as the original.

______☐**REFERRALS**: If you are an HMO or managed care patient, you will need to obtain a referral form from your primary care doctor. It is the patient's responsibility to obtain the referral prior to your visit. Please initial even if you do NOT have an HMO policy. This states you acknowledge our policy if your insurance changes in the future.

______☐**MEDICARE PATIENTS ONLY**: I request payment of authorized Medicare benefits be made on behalf to Heart One Associates for any services furnished to me by the physician, I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

______☐**I have read and understand the information on this form.**

______________________________________ ________________________

(Signature) (Date)

FINANCIAL POLICY

Thank you for choosing Heart One Associates. We are committed to providing our patients with the highest quality medical care. This financial policy is an important part of your health care. Due to increased insurance company demands, we ask you to read and agree to the following:

We make every attempt to accept a wide range of insurance plans. For the patients convenience we file medical claims with insurance plans with which we have an agreement, as long as the valid insurance information is provided to us. However, all policies have different benefits, and we cannot know the specific details of each individual policy. **It is the patient's responsibility to know their individual policy and to verify all benefits and coverage information prior to having any services rendered. Also the patient is responsible for notifying us of any changes to his or her insurance plan or policy prior to his or her visit.**

Co-pays and Deductibles: Insurance policies are an agreement between the patient and his or her insurance company. Contracting with health insurance companies requires us to collect co-pays and deductibles. The patient must pay this amount prior to seeing any of our healthcare providers

Additional Fees: If the patient does not have medical insurance or if Heart One Associates is not a contracting provider with his or her insurance carrier, all chargers incurred during treatment will be due and payable at time of service. A $25.00 charge will be applied to all checks returned.

If a patient is unable to keep a scheduled appointment, we must be notified 48 hours in advance. Appointments cancelled after the time frame may be subject to a cancellation fee. Additionally a missed appointment for a Nuclear Stress test will be a $200.00 charge and will be discussed at the time of scheduling.

Any medical records request sent to someone other than a physician will be subject to a fee.

Timely payment: If for any reason the patient incurs an account balance, we will mail a statement. Payment is due from the patient upon receipt of the first statement from our office. If the balance is not paid in full, Heart One Assoc reserves the right to send the patients account to collections and an additional 33% collection fee will be added. Please be aware that any delinquent account balance may prohibit the patient from scheduling future appointments.

Financial Hardship: Our Mission of providing twenty-first century cardiovascular science and technology with timeless compassion and care prompts us to provide care to our patients regardless of their ability to pay. This means that we will work collaboratively with patients who are under financial hardship to develop fair and reasonable payment plans. Financial hardship is determined by policy and is a formal process that must be a joint effort between our financial counselor and the patient. The patient will be asked to provide documentation and a full explanation of extenuating circumstances regarding their hardship. Extenuating and/or special circumstances will not include patients that have over extended themselves financially. A patient who has the ability to pay and has not been formally determined to be in a financial hardship is expected to pay at the time of service and maintain no outstanding balance.

I have read and understand the Heart One Associates financial policy. I authorize Heart One Associates to obtain and/or release medical information necessary for filing insurance claims on my behalf and for the purposes of healthcare management. I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me to be paid directly to Heart One Associates. Should insurance payment be made directly to the insured, I agree to immediately pay these funds to Heart One Associates.

____________________	____________________	____________________
Patient Name (Please print)	Signature	Date

NOTICE OF PATIENT INFORMATION PRACTICES

Heart One Associates is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described.

USES AND DISCLOSURES OF HEATLH INFORMATION

Heart One Associates uses your personal health information primarily for treatment; obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide.

Heart One Associates may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any situation, Heart One Associates policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Heart One Associates may change its policy at any time. You may request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Heart One Associates will consider all such requests on case by case basis, but the practice is not legally required to accept them.

NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received the Heart One Associates Notice of Patient Information Practices.

______________________________	______________________________	______________________
Patient Name (Please print)	Signature	Date

E-PRESCRIBING CONSENT FORM

Heart One Associates is in the process of implementing ePrescribing:

- ePrescribing is a federally mandated initiative that requires all physicians prescribe in the manner by 2011.
- ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

PATIENT CONSENT:

I agree that Heart One Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

______________________________	______________________________	______________________
Patient Name (Please print)	Signature	Date
______________________________	______________________________	(______)_________-___________
Pharmacy Name	Pharmacy Address	Pharmacy phone#

Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you.

Date: ______________________________

Name: __________________________________ **Date of Birth**: _____________________ **Age**: _______________

Referring Physician: ____

Reason for Visit: ____

How did you hear about us?
☐ Website ☐ Hospital ☐ Friend/Relative ☐ Referral from PCP ☐ Insurance
☐ Add/Newspaper ☐Drive by ☐ Word of mouth ☐ Other ____________________________

Personal Medical History:

Disease/Condition	Yes	No	When were you diagnosed?
Heart attack (Myocardial Infarction)			
Heart surgery (Bypass)			
Heart Valve disease			
Heart Valve surgery (Replacement/Repair)			
Peripheral Vascular Disease			
Vascular Surgery			
Congestive Heart Failure			
High Blood Pressure (Hypertension)			
Diabetes Mellitus (Type I or II)			
High Cholesterol (Hypercholesterolemia)			
History of Stroke or TIA			
Thyroid Problem			
Bleeding/Clotting Tendencies			
History of Cancer (Malignancy)			
Lung Disease			
History of Kidney Disease			
Other Problems:			

Medications: Prescription and non-prescription medicines, home remedies, birth control pills, herbs.

Medication	**Dose**	**How many/Day**	**Medication**	**Dose**	**How many/Day**

Allergic to Iodine, Shellfish, or x-ray dye: ☐ No ☐ Yes

Medications you are allergic to: Reaction:

___________________________________ ___________________________________

___________________________________ ___________________________________

Cardiac Testing History: Please indicate whether you had any of the following tests performed?

Procedure/Test	Yes	No	Where/When?
Heart Catheterization of Angiogram			
Heart Stent			
EKG			
Nuclear Stress Test			
Echocardiogram			
Carotid ultrasound			
CT Angiogram			
Electrophysiology Study			

Family History: Please indicate the current status of your immediate family members:

Relation	Alive	Deceased	Age (Now or at death)	Comments/Cause of Death
Mother:				
Father:				
Sister (s) #_____				
Brother (s) #_____				
Daughter (s) #_____				
Son (s) #_____				

Occupation:____________________________ Employer:_____________________________

Years of Education/Highest Degree_____________________ Marital status ☐ S ☐ M ☐ D ☐ W Other:___

Spouse/Partner's Name:______________________________ Number of Children/Ages:________________

Who lives at home with you? ____

Social History

Tobacco Use: ☐ Current ☐ Former ☐ Never If former, Year Quit: ________________________

If Yes, Type: ☐ Chewing ☐ Cigarette ☐ Pipe ☐ Smokeless

Packs/day _______________ Years Used _________________ Passive Smoke Exposure ☐ No ☐ Yes

Alcohol Use: Do you drink alcohol? ☐ No ☐ Yes # of Drinks /Week: ___________________________

Drug Use: Do you use recreational use? ☐ No ☐ Yes

Have you ever used needles? ☐ No ☐ Yes

Sexually Active: ☐ No ☐ Yes ☐ Not Currently

History of Erectile Dysfunction (Males Only): ☐ No ☐ Yes

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No Cups per day _______________________

If Yes, What Type: ☐ Sodas ☐ Coffee/Tea ☐ Energy Drink ☐ Chocolate ☐ Other: _____

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise? __________________ How long (minutes)? ______________ How often? _________

If you do not exercise, why? ____

Advanced Directives: ☐ None ☐ DNR ☐ HC Proxy ☐ Living Will

Do you have a POA? YES ____ No____ If yes who is your designated POA __________________________

Relationship: ____________________________ Phone #:_______________________________________

Review of Systems: Please check (✓) any current problems you have on the list below:

Constitutional ____ Fever/Chills/Sweats ____ Unexplained weight loss/gain ____ Change in Energy/Weakness ____ Excessive thirst or urination	**Genitourinary** ____Nighttime urination ____Leaking urine ____Unusual vaginal bleeding ____Discharge: penis or vagina
Eyes ____ Change in Vision	**Musculoskeletal** ____Muscle/joint pain
Chest (breast) ____Breast lump/nipple discharge	**Skin** ____Rash/Mole Change
Cardiovascular ____Chest pain/discomfort ____ Palpitations ____ Shortness of breath ____ Ankle Edema	**Neurological** ____Headaches ____Dizziness/Lightheaded ____Numbness ____Memory Loss ____Loss of coordination
Ears/Nose/Throat/Mouth ____Difficult hearing/ringing in ears ____Problems with teeth/gums ____Hay Fever/Allergies	**Psychiatric** ____Anxiety/Stress ____Problems with sleep ____Depression
Respiratory ____Cough/Wheeze ____Difficulty Breathing	**Gastrointestinal** ____Abdominal pain ____Blood in bowel movement ____Nausea/Vomiting/Diarrhea
Blood/Lymphatic ____Unexplained lumps ____Easy bruising/bleeding	**Other** ____ Problems with sexual function

Vitamins & Supplements: Please check (✓) any supplements that you are currently taking:

Supplement	**Dose**	**Supplement**	**Dose**
____Multivitamins	_____	____Beta Carotene	_____
____Vitamin B3 (niacin)	_____	____Calcium	_____
____Vitamin B6	_____	____Garlic	_____
____Vitamin B12	_____	____Magnesium	_____
____Vitamin B Complex	_____	____Mineral Supplement	_____
____Vitamin C	_____	____Omega-3 Fatty Acid	_____
____Vitamin D	_____	____Potassium	_____
____Vitamin E	_____	____Zinc	_____
____Herbal/black/green Tea	_____	____Saw Palmetto	_____
____Herbal Mixtures	_____	____St. John's Wort	_____
____Ma huang/ephedra	_____	____Metabolite	_____
____Plant Steroids	_____	____Ginkgo	_____
____Grape Seed Extract	_____	____Other________________________________	