Patient Information

Personal Information

Last Name: _____ **Middle Name:** _____ **First Name**: _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____

City: _____ **State**: _____ **Zip Code:** _____

Home Number: _____ **Cell Number**: _____

Email: _____

Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ American Indian/Native Alaskan ☐ Black/African American ☐ Asian

☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Other _____

How Did You Hear About Us? ☐ Friend/Family ☐ Referral from PCP ☐ Hospital ☐ Our Website

☐ Insurance ☐ Google/Yelp ☐ Social Media ☐ WedMd/Vitals

Preferred Language: _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____

Advanced Directives: ☐ None ☐ DNR ☐ Living Will ☐ On File

Signature: _____ **Date:** _____

Insurance Information

Primary Insurance Company: _____ **Relation to Subscriber:** _____

ID No: _____ **Group No:** _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN:** _____

Secondary Insurance Company: _____ **Relation to Subscriber:** _____

ID No: _____ **Group No:** _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN:** _____

Patient Medical History

Patient Name (Please Print): _____ Date: _____Date of Birth: _____

Personal Medical History

Disease or Condition	Yes	Month/Year Diagnosed
Heart Attack (Myocardial Infraction)		
Heart Surgery (Bypass)		
Heart Valve Disease		
Heart Valve Replacement		
Heart Valve Repair		
Peripheral Vascular Disease		
Vascular Surgery		
Congestive Heart Failure		
High Blood Pressure (Hypertension)		
Diabetes Mellitus (Type I or II)		
High Cholesterol (Hypercholesterolemia)		
Stroke		
TIA		
Thyroid Problem		
Bleeding or Clotting Problems		
Cancer (Malignancy)		
Lung Disease		
Kidney Disease		
Other Problems		

Immediate Family History

Relation	Alive	Deceased	Age (Current or at Death)	Cause of Death

Cardiac Testing History

Procedure	Yes	When	Where
Hearth Catheterization of Angiogram			
Heart Stent			
EKG			
Nuclear Stress Test			
Echocardiogram			
Carotid Ultrasound			

CT Angiogram (CTA)			
Electrophysiology Study			

Current Symptoms or Problems of Concern

Cardiovascular	**Blood/Lympha**
__Chest pain	__ Unexplained lumps
__Shortness of breath	__Easy Brusing/bleeding
__Palpitations	__ Blood in stool
__Ankle edema	__ Other _____

Pharmacy: _____ Address (Cross Streets): _____

Medications

Medication	Dose	How Many Times a Day

Allergies

Are you allergic to iodine, shellfish, or X-ray dye? ☐ No ☐ Yes

Allergies to Medications	Reaction

Social History

Tobacco Use: ☐Current ☐ Former **Year Quit:** _____ ☐ Never

If yes, which of the following: ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Vape

Packs Per Day: _____ **Years Used:** _____

Alcohol Use: ☐ No ☐ Yes **Number of Drinks Per Week:** _____**Drug Use:** ☐ No ☐ Yes _____

Are You Sexually Active: ☐ No ☐ Yes

Do You Drink Caffeine: No☐ Yes ☐**Cups a day:** _____ **Type:** Coffee/Tea☐ Soda☐ Energy Drink☐ Other_____

Financial Policy

Thank you for choosing Heart One Associates. We are committed to providing our patients with the highest quality medical care.

Please note: It is the patient's responsibility to know their policy and verify all benefits and coverage information before services are rendered. Also, the patient is responsible for notifying Heart One Associates of any changes to his/her/their insurance plan and/or policy before the visit. If your insurance policy requires a referral from your primary care provider, you will have to obtain that referral prior to your visit at our clinic.

Co-pays and Deductibles

Insurance policies are an agreement between the patient's insurance company. Contracting with health insurance companies requires Heart One Associates to collect co-payments and deductibles. ***All copays are collected at the time of service.***

Additional Fees

- A $25 charge will be applied to all checks returned.
- If a patient is unable to keep a scheduled appointment, Heart One Associates must be notified **48 hours in advance**. There is a $75 no-show fee that will be added to patient's account for any Nuclear Stress test appointments. This will be discussed at the time of scheduling.
- Medical record requests ***will be subject to a $35 fee***. This includes FMLA or disability information. Records ***over 50 pages will be subject to a $25*** fee. Medical record ***turnaround time is between 7 and 10 business days***.

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

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 healthcare management. I assign all benefits to which the patient or insured is entitled to my treatment and medical services provided to me to be paid directly to Heart One Associates. Payment arrangements may be available and are determined on a case-by-case basis for those experiencing financial hardship.

Patient Name (Please Print): _____ **Today's Date:** _____

Patient Signature: _____

HIPAA Notice of Patient Information Practices Privacy Information

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 Health 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 (PHI) without prior authorization for public health purposes, auditing purposes, and emergencies. We also provide information when required by law.

Please note that we may occasionally update our practices regarding the use, disclosure, and patient rights of medical information. We reserve the right to change this notice and apply it to all medical information we maintain.

Breach Notification: You have the right to be notified in writing following a breach of your unsecured medical information.

Patient's Rights

You have the right to review or obtain a copy of your PHI at any time.

Notice and Acknowledgement

I_____ acknowledge that I have received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE unless I complete and return an Opt-Out Form to my healthcare provider.

Patient Signature: _____ **Today's Date:** _____

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you are insured by a state-regulated HMO or PPO insurance plan (including the state employee and teacher retirement systems), Texas law also protects you from surprise medical bills for emergency services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory,

neonatology, assistant surgeon, hospitalist, or intensivist services. **These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.**

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Under Arizona law, if you received health care services at an in-network facility, you may seek arbitration of qualifying out-of-network bills.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must: o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Arizona Department of Insurance and Financial Institutions at 1(602) 364-3100.

Visit https://www.cms.gov/nosurprises/consumers or call (800) 985-3059 for more information about your rights under federal law.

Visit https://difi.az.gov/consumer/i/health/surprisebil l for more information about your rights under Arizona law or call (602) 364-3100