

Cardiovascular Consultants, Inc



New Patient Information

Dear Patient:

Please complete the following forms and bring them with you to your doctor's appointment. Also, to make our billing procedures easier, please bring your insurance cards with you. Check with your primary care doctor as well to see if an insurance referral is needed, as we will need confirmation of that at the time of your appointment.

Our physicians and nurses want to provide you with the best quality health care. We appreciate you bringing your medications with you in their original bottles to all your appointments with us.

Thank you.

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the medical records department.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: 04/01/03

NAME: _____ AGE: _____ DATE: _____ REF. DR: _____

Please help us find out about you by filling out the "Patient" side of this form on pages 1-3
Please leave "Clinician" side blank.

PATIENT **CLINICIAN**

Why are you here to see a Cardiology (heart) doctor? CC

Check off any heart problems or symptoms: HPI

- Heart attack
- High blood pressure
- Abnormal rhythm (arrhythmia)
- Palpitations/irregular heart beats
- Fainting
- Enlarged heart
- Chest pains or pressure
- Shortness of breath
- Dizziness
- Swollen legs
- Heart failure
- Blue lips or fingernails
- Leg cramps when you walk

Have you ever had:

- A stress test
- An Echocardiogram
- Cardiac Catheterization/Heart Catheterization
- Coronary Angioplasty (balloon/atherectomy/stent)
- Coronary Bypass Surgery
- Valve Surgery
- An Electrophysiology Study or Procedure
- A Pacemaker or Defibrillator

Tell us about your risk of heart disease.

Please check if you have:

- High blood pressure
- High cholesterol
- Ever smoked
- Diabetes

Do you exercise (including walking)?

- Yes No

Has a close family member had a heart attack, chest pain or bypass surgery? _____

Who? _____

If you are a woman, have you passed menopause (change of life)? _____

At what age? _____

Do you take estrogen? _____

Please tell us anything else about your heart:

Health Habits:

Do you smoke? _____

How many packs per day? _____

For how many years? _____

How much alcohol do you drink? _____

Do you use any recreational drugs? _____

- Yes No

List: _____

PATIENT

CLINICIAN

PAST FAMILY SOCIAL HISTORY

Are you being treated now or have you been treated for any illnesses or diseases.

Past Med Hx

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Have you ever had any operations? Any injuries?

Past Surg Hx

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Marital Status: S M W D

Social Hx

With whom do you live? _____

Occupation: _____

Leisure Activities: _____

Education Level: _____

Check if any close family members (parents, brother, etc.)

Family Hx

- Heart problems
- High blood pressure
- Diabetes
- Cancer

Are there any other health problems in your family?

Are you allergic to any medications?

Allergies

- Yes No

List medications to which you are allergic.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Do you have hay fever?

- Yes No

What is your reaction?

Have you had the following vaccinations?

Vaccinations

- Influenza (Flu Shot) Annually
- Pneumococcal (Pneumonia) Vaccine

PATIENT

CLINICIAN

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications and vitamins.

Constitutional

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Please circle any symptom you have, so we can find out more about it:	REVIEW OF SYMPTOMS
Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers	Constitutional
Eye problems, such as double or blurred vision; glaucoma; cataracts	HEENT
Hearing problems; buzzing or ringing in the ears	
Allergies; hay fever	
Sinus problems	
Blood pressure or heart problems	Cardiac
Asthma; tuberculosis	Pulmonary
Stomach problems; heartburn; indigestion; change in bowel habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems; Frequency; infections; stones; bladder	Urinary
Men: Prostate problems; night-time urination	
Women: Abnormal menstrual periods; could you be pregnant?	
Joint pains, swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skin problems	Dermatological
Women: breast lumps; recent mammogram; pap smear and/or pelvic exam	Female Reproduction
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorder; diabetes; excess thirst, hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological

CARDIOVASCULAR CONSULTANTS, INC. PS

FINANCIAL AGREEMENT, EXTENSION OF CREDIT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself, shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon.

In accordance with the Federal Truth-in-Lending Act; which requires us to give our patients information in connection with extension of credit, please be advised of the following policies, which apply in this clinic. The responsible party agrees:

1. To pay cost and/or reasonable attorney fees if any delinquent balance is placed with an agency or attorney for collection or suit.
2. **NSF FEES:** If a patient writes an NSF check (non-sufficient funds) or issues a stop payment, an administrative fee of \$26.00 will be added to the patient's account.
3. **NO SHOW FEES:** Because of the time allotted for each patient visit, those individuals who do not keep their appointments or do not cancel within 24 hours in advance will be subject to a no-show fee of \$50.00. Nuclear imaging appointments will be charged a \$300.00 no-show/cancellation fee.
4. **COPAYS:** We require any copayment **at the time of service**, otherwise you may be billed an additional \$25.00 copay billing fee.

About health insurance:

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.
- IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS. THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, YOU SHOULD CONTACT YOUR CARRIER IMMEDIATELY.
- We will bill your insurance claim for you. If you have a secondary insurance, we will bill it one time only, as a courtesy, as long as you have provided us with the appropriate information. You will be responsible to re-bill this secondary insurance if that becomes necessary. If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent. If you have a third insurance, it will be your responsibility to bill them.

REFERRALS: It is your responsibility to obtain the appropriate referral from your primary care physician. We will assist you with this if necessary; however, your appointment may have to be rescheduled if the appropriate referrals are not in place on the date of your appointment.

It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereof, and all proceeds of insurance are assigned to the office where applicable, but without their assuming responsibility for the collection thereof. A copy of the assignment is as valid as the original.

Accounts 30 days past due are subject to collection proceedings, except when prior arrangements have been made with our business office.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Business Office as soon as possible by calling (253) 735-6083.

I authorized and request my insurance company to pay directly to Cardiovascular Consultants, Inc., PS., insurance benefits otherwise payable to me, for any services furnished to me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

FOR YOUR CONVIENIENCE WE ACCEPT CASH, CHECKS, VISA & MASTERCARD.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ DATE: _____

Please PRINT name

Cardiovascular Consultants, Inc



Notice of Privacy Practices (HIPAA)

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Cardiovascular Consultants respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
 - medical quality review by your health plan;
 - accounting, legal, risk management, and insurance services;
 - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact us at 253-939-1230.

Our Responsibilities

We are required to:

- Keep your protected health information private;

- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our offices to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact us at 253-939-1230.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Administrator at our facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you notify us in writing to the contrary, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- Hospital Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
 - your name,
 - location,
 - general condition, and
 - religion (only to clergy).

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- With Medical Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.

- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To Comply With Workers' Compensation Laws—if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
 - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
 - to public health or legal authorities:
 - to protect public health and safety
 - to prevent or control disease, injury, or disability
 - to report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.cvcwa.com.