Advanced Heart and Vascular Center

Demographic Information

Patient Information

Last Name: ____________________ First Name: ________________ MI: _____

Date of Birth: ______________________________ Gender: __________________

Street Address: ____ City: _______________________________ State: _____ Zip: __________

Mobile # _________________ Home # ________________ Work # _____________

Email Address: ____

Pharmacy Name/Address:____

Pharmacy Phone Number: ____

Responsible Party (if different from above)

Last Name: ___________________ First Name: ________________ MI: _____

Date of Birth: _________________ Relationship to Patient: ________________

Street Address: ____

City: ______________________________ State: _______ Zip: ___________

Emergency Contact

Last Name: ___________________ First Name: ________________ MI: _____

Relationship: _______________________ Phone Number(s): _______________

Last Name: ___________________ First Name: ________________ MI: _____

Relationship: _______________________ Phone Number(s): _______________

Medical Decisions Made By: Self: ___ OR Other (Name): ___________________

SIGNATURES RELEASE AND HIPAA AUTHORIZATION FORMS

FINANCIAL POLICY

Payment Policy

All services rendered by Advanced Heart and Vascular Center are charged directly to the patient on the date of service based on an estimate of patient responsibility from the insurance carrier provided. These charges may represent any allowable copays, deductibles and coinsurance amounts assigned by the patient's insurance carrier. We will file all necessary insurance forms and credit their payments to your account. A statement will be sent for any remaining balances.

Any patient overpayment greater than $10.00 will be refunded by check once the claim is finalized. Credit balances less than $10.00 will be held for future visits unless requested by the patient.

If you do not have insurance, payment in full is due on the date of service for any services provided.

Payment of your charges is ultimately your responsibility and you, as the patient, agree to comply with our policy.

Cash Payment Policy

We offer a 20% discount of our fee schedule at the time of service for cash payment in full for services rendered for patients without insurance.

Returned Check Fee

There will be a $35.00 charge for all returned checks.

Cancellations and Missed Appointments

We received many requests from patients who have urgent need for care. We kindly request that you allow at least 24-hour notice of a cancellation. We contact all patients prior to the day of their scheduled appointment in order to confirm the appointment. If we do not receive 24-hour notice, we reserve the right to charge a cancellation fee of up to $35.00 to the patient or responsible party.

Patients with multiple missed appointments and/or cancellations may be discharged from our practice.

____

Signature of Patient or Responsible Party   Date

____

Printed Name of Patient   Date of Birth

CONSENT OF PROFESSIONAL SERVICES, INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I consent to treatment/services necessary for the care of my present condition.

I authorize holder of medical and other information about me to release any information needed for treatment, payment, healthcare operations, and as otherwise allowed by law. A copy of Advanced Heart and Vascular Center's Notice of Protected Health Information Practices will be provided upon request.

I hereby assign, transfer and set over to Advanced Heart and Vascular Center my assignment of benefits for reimbursement of services.

This consent/authorization/assignment will remain in effect until revoked by me, the patient, in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for any charges not paid by said insurance.

____ ____________________________

Signature of Patient or Responsible Party   Date

____ ____________________________

Printed Name of Patient   Date of Birth

DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY AND FRIENDS

Name of Patient:___________________________________ Date of Birth __________________

I, the undersigned, hereby authorize Advanced Heart and Vascular Center to disclose information from my medical or financial records to the following people:

☐Name:___________________________________ Relationship:__________________________

Contact Information:____

Type of Information to be released: __________Medical____________Financial_________Both

☐Name:___________________________________ Relationship:__________________________

Contact Information:____

Type of Information to be released: __________Medical____________Financial_________Both

This Authorization is given freely with the understanding that, 1) I may revoke this authorization at any time, but not retroactively, by letting Advanced Heart and Vascular Center know in writing, and 2) Advanced Heart and Vascular Center, its employees, officers, and the physician are hereby released from legal responsibility or liability for the disclosure of the information I authorized previously.

Signature of Patient ___________________________________ Date: __________________

Electronic Medical Record Exchange Policy

I understand and acknowledge that Advanced Heart and Vascular Center participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from Advanced Heart and Vascular Center or Exchange Participants, my health information may be shared electronically between Advanced Heart and Vascular Center and Exchange Participants in order to provide care and services to me, and I do hereby authorize Advanced Heart and Vascular Center to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses of treatments for substance abuse, mental illness (excluding psychotherapy notes) or communicable diseases (including HIV or AIDS), and that some sensitive information cannot be disclosed through the medical record exchange program without a separate authorization by me.

Signature of Patient or Legal Guardian ______________________________ Date ___________________

Advanced Heart and Vascular Center

New Patient Health Questionnaire

DATE: ____/____/____

Name: ____ Gender: M / F

Date of Birth: ______________________________________ Age: _____________ Referring

Doctor: __________________________________

REASON(S) FOR VISIT

1. Chest Pain 7. Heart Murmur
2. Shortness of Breath 8. Dizziness / Fainting
3. Palpitations 9. Pre- surgical Evaluation
4. Heart Failure 10. Abnormal Rhythm
5. Stroke or TIA
6. Other (Please Specify):____

PREVIOUS HEART HISTORY

1. Pacemaker / ICD Year:______________
2. Heart Cath / Angioplasty / Stent Year:______________
3. Coronary Bypass Surgery Year:______________
4. Other Heart Procedures:____

RISK FACTORS

1. High Cholesterol NO YES Year:______________
2. High Blood Pressure NO YES Year:______________
3. Diabetes NO YES Year:______________
4. Cigarette Smoker NO YES (Quit)Year:______________
5. Parent/Sibling with Heart Disease NO YES Who?______________

SURGICAL HISTORY (LIST PREVIOUS OPERATIONS).

1. ____ Year:______________
2. ____ Year:______________

Advanced Heart and Vascular Center

Medications – *Please bring actual bottles*

	NAME	DOSE	FREQUENCY
1.	______________________	____________	________________
2.	______________________	____________	________________
3.	______________________	____________	________________
4.	______________________	____________	________________
5.	______________________	____________	________________
6.	______________________	____________	________________
7.	______________________	____________	________________
8.	______________________	____________	________________

DRUG ALLERGIES

	MEDICATIONS	REACTION
1.	____________________________	____________________________
2.	____________________________	____________________________
3.	____________________________	____________________________

SOCIAL HISTORY

Occupation: ____

Marital Status: Married Divorced Widowed Single

Exercise Program: ____

Diet: ____

Alcohol Intake: ____

Name: ____________________________ Date: _______________________

Date of Birth: _______________________

Primary Care Doctor: _____________________

Please mark any of the symptoms you have had in the last one to two weeks:

Constitution	**Eyes**	**Gastrointestinal**	**Endo/Heme/Allergy**
Fever	Blurred Vision	Heartburn	Easy bruising
Chills	Double Vision	Nausea	Allergies
Weight Loss	Sensitive to Light	Vomiting	Excessive thirst
Fatigue	Eye Pain	Abdominal pain	**Neurological**
Sweating/ Perspiration	Eye Discharge	Diarrhea	Dizziness
Weakness	Eye Redness	Constipation	Tingling
Skin	**Cardiovascular**	Blood in Stool	Tremor
Rash	Chest Pain	Black stool	Sensory Change
Itching	Palpitations/Flutter	**Genitourinary**	Speech change
HENT	Shortness of breath lying down	Painful urination	Focal Weakness
Headaches	Leg cramps	Urgency	Seizures
Hearing Loss	Leg Swelling	Urinary Frequency	Loss of Consciousness
Ringing in Ears	Waking from sleep short of breath	Blood in urine	**Psychiatric**
Ear Pain	**Respiratory**	Flank Pain	Depression
Ear Discharge	Cough	**Musculoskeletal**	Suicidal Ideas
Nosebleeds	Coughing up blood	Muscle pain	Substance Abuse
Congestion	Sputum production	Neck pain	Hallucinations
Sore Throat	Short of breath	Back pain	Nervous/Anxious
	Wheezing	Joint pain	Insomnia
		Falls	Memory Loss