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PATIENT INFORMATION

Patient Name: (Last) _____ __ **(First)** _____ **(MI)** _____

Address: _____**Apt/ Space#** _____

City:_____ __ **State:** _____**Zip:** _____

Date of Birth: _____ /_____/_____ **Male**: ☐ **Female** : ☐ **Soc. Sec. Number:** ____ - ____ - ____

Home # (____) ____- _____ **Work #** (____) ____- _____ **Cell #** (____) ____ - _____

Email : _____

Primary Care doctor: _____ **Phone:** (_____) _____ - _____

Referred by :□ Self □ Friend □Insurance □**Doctor** _____Phone (____)____- _____

Pharmacy : (Local with cross streets) _____

Mail Order Pharmacy _____

☐ **By checking this box, I authorize Cedars Heart Clinic, LLC and its affiliated providers to view my external prescription history.**

Race : American Indian Asian Black or African American White Hispanic
Native Hawaiian Pacific Islander White Alaskan Do not wish to respond

Ethnicity: Not Hispanic Hispanic / Latino Do not wish to respond

Language Preference: English Other _____ Do not wish to respond

Marital Status: Married Single Widowed Separated Divorced Do not wish to respond

Name of Spouse/ partner : _____ **Phone #**(_____)_____

Emergency Contact : _____ **Phone #** (_____)_____

Do you have an Advance Directive (Living Will/ Power of Attorney) ? Yes No

Would you like to provide us with a copy? Yes No

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Do you leave for the summer? Yes No **What months are you in AZ?** _____to _____

Summer Address: _____

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

RESPONSIBLE PARTY INFORMATION

Name: _____ Home #: (____) ____ - _____ Work # (____) ____- _____

Address: _____

City: _____ State : _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ ID# _____ Group# _____

Policy Holder: _____ _____DOB: ____/ ____/ _____

Relationship to the patient: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ ID# _____ Group# _____

Policy Holder: _____ _____DOB: ____/ ____/ _____

Relationship to the patient: _____

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I understand I am financially responsible for all charges related to the services provided to me including any balance remaining after payment of possible benefits. I authorize payment under my insurance program (s) to be made directly to CEDARS HEART CLINIC, LLC for services provided to me.

I further authorize CEDARS HEART CLINIC, LLC to release all or part of my medical records by hardcopy or electronic transmission to me, to my physician(s) and medical insurance plan(s)listed above and to my place of employment. I permit a photocopy , hardcopy or electronic transmittal of this signed authorization and release to be considered as effective and valid as the original and in force from the date of signing until revoked in writing.

MEDICAL TREATMENT: I authorize CEDARS HEART CLINIC, LLC to examine me, administer treatment and perform procedures as are medically and/or diagnostically necessary.

Patient Signature_____**Date**_____

Name and signature of Power of Attorney/Legal Guardian_____

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CONSENT TO RELEASE PRIVATE HEALTH INFORMATION

In keeping within the laws of the Arizona's Notice of Privacy Practices and the Health Insurance Portability and Accountability Act of 1996 **(HIPAA),** I request for my **private health information (PHI)** to be handled as indicated below.

Please check one option ONLY:

□ Do not release/ discuss any of my **private health information (PHI)** with anyone other than myself.

□ I give consent for Cedars Heart Clinic and designated staff to discuss, receive and or disclose my **private health information (PHI)**, including but not limited to, appointments, diagnosis, prognosis, medications, results of lab, X-rays, diagnostic tests, etc. **to the people listed below**. This consent is to be extended for an indefinite period of time unless I notify Cedars Heart Clinic in writing.

Name	Relationship to the Patient and Phone Number

I further extend this authorization to include my emergency contact listed below:

Name	Relationship to the Patient and Phone Number

□ Yes, I give my permission to leave detailed messages regarding my **PHI** at the following phone numbers (_____) _____ - _____, (_____) _____ - _____

□ No, do not leave any detailed messages regarding my **PHI**

Cedars Heart Clinic has given me the opportunity to receive and/or review a copy of Arizona's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Power of Attorney/Legal Guardian Signature of Power of Attorney/Legal Guardian

_____
Relationship to Patient

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FINANCIAL AND OFFICE POLICIES

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial or office policy or your responsibility.

- **As our patient, it is your responsibility to provide us with accurate information** including your billing and insurance information as well as medical information prior to seeing the doctor.

- **If you are unable to keep appointments you have scheduled**, we need a 24 hrs. notice, otherwise a $25.00 fee may be assessed.

- **If your insurance requires a prior authorization/ referral from your primary doctor for a specialist office visit**, the referral must be available prior to your scheduled appointment to avoid the cancellation of your appointment.

- **Co-insurances, Deductibles, Copayments and Balances are required at the time services are rendered**. The dues are determined by your insurance and were agreed upon by you at the time you selected your insurance policy. We accept cash, checks, Visa, Mastercard, American Express and Discover.

- **There will be a fee of $35.00 for any returned checks as well as returned transactions.**

- **We will gladly file a claim to your insurance company as a courtesy**. You, however, will be required to pay any DEDUCTIBLE, CO-INSURANCE and/or COPAYMENTS at the time of service. If the insurance company fails to pay for the services provided within sixty (60) days, you will be required to pay the balance of your bill within thirty (30) days of the statement date, or your bill will be sent to collections. Any payments received from your insurance carrier after you have paid your balance will be REFUNDED to you. Should you have any insurance changes such as, policy numbers or insurance companies, you will need to bring in your new card or provide us with the updated information. Otherwise, you will be responsible for any charges for services rendered to you.

- **If you have no insurance coverage**, payment in full is expected at the time treatment is rendered

- **Any billing questions or concerns** will be addressed by our Billing and Accounts Receivable Manager. You may direct any of these concerns to our office by calling 480-917-5900 option 4. Please leave a message and allow 48 business hours for a response.

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- **It is your responsibility** to advise us of any address, phone number, medical history, medication, or insurance changes at the time of your appointment or by visiting our patient portal and updating your information.

- **If you need your medical records** to be released to yourself, another physician practice or any other entity, a medical records release form must be completed and signed prior to the records being released. Please allow 7 to 10 working days for these records to be processed by our office.
- **For emergency treatment after hours**, an answering service is available by calling our main number (480-917-5900 or 520-836-6661). If your situation is such that you cannot wait for the physician to be located, go immediately to the Emergency Room closest to you or dial 911.

- **If you need a prescription refill**, please call your pharmacy **AT LEAST 72** hours before it is needed. The pharmacy, in most cases, will contact us. Our staff makes every effort to respond the same day. Sometimes, however, this is not possible.

    - **There will be a charge of $50.00 for each and any administrative forms filled.**

By signing this policy, you agree to abide by the financial and office policies of CEDARS HEART CLINIC, LLC.

I AGREE TO PAY ANY/ALL CHARGES, COLLECTION COSTS, ATTORNEY FEES OR ANY ADDITIONAL COST THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUTSTANDING ON THIS ACCOUNT.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Power of Attorney/Legal Guardian Signature of Power of Attorney/Legal Guardian

_____
Relationship to Patient

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MEDICAL HISTORY

CURRENT MEDICATIONS (INCLUDE PRESCRIPTION AND OVER THE COUNTER) ☐ See attached list

Name of Medication	Dosage	How Often Taken

ALLERGIES TO MEDICATIONS

Name of Medication	Type of Reaction

LIST ALL SERIOUS INJURIES , ILLNESSES OR SURGERIES

Date (Year)	Injury, Illnesses, Surgeries (Operations)

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Patient Medical History Form

Past Medical History

Heart Attack	O Yes	O No
Liver Problems	O Yes	O No
Heart Murmur	O Yes	O No
Rheumatic Fever	O Yes	O No
Angina	O Yes	O No
Diabetes	O Yes	O No
Hypertension	O Yes	O No
High Cholesterol	O Yes	O No
Irregular heart beats	O Yes	O No
Blood Clots	O Yes	O No
Kidney Failure	O Yes	O No
Stroke	O Yes	O No
Bleeding Disorders	O Yes	O No
Fibromyalgia	O Yes	O No
Thyroid Disorders	O Yes	O No
Peripheral Vascular Disease	O Yes	O No

Surgical History

Coronary Artery Bypass Graft	O Yes	O No
Pacemaker/ICD Placement	O Yes	O No
Cholecystectomy	O Yes	O No
Appendectomy	O Yes	O No
Hysterectomy	O Yes	O No
Coronary artery stent/Angioplasty	O Yes	O No
Aortic Valve Replacement	O Yes	O No
Mitral Valve Replacement	O Yes	O No
Knee Replacement	O Yes	O No
Hip Replacement	O Yes	O No

Social History

Do you smoke?	O Yes	O No
Do you drink alcohol?	O Yes	O No
Have you used drugs?	O Yes	O No

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Patient Questionnaire

Are you at risk for Peripheral Vascular Disease?

Name: _____ Date of birth:_____

Date:_____

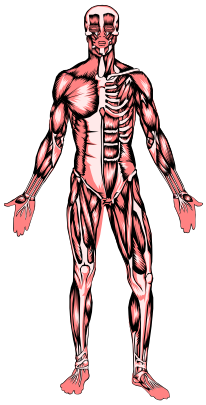
Peripheral vascular disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged. Please fill out this questionnaire to see if you have symptoms of Peripheral Vascular Disease.

Circle Yes or No to the following questions:

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs, or buttocks? Yes No

2. If you answered yes, does the pain subside with rest? Yes No

If applicable, circle the area of the body on the diagram below where you feel pain:



3. Do you have any painful sores or ulcers on your legs or feet that aren't healing? Yes No

If you have answered any of the above you may be at risk for PVD.