CARDIOVASCULAR INTERVENTIONS, P.A.

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ICAEL Accredited Echocardiography Laboratory

ICANL Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

NEW PATIENT PACKET

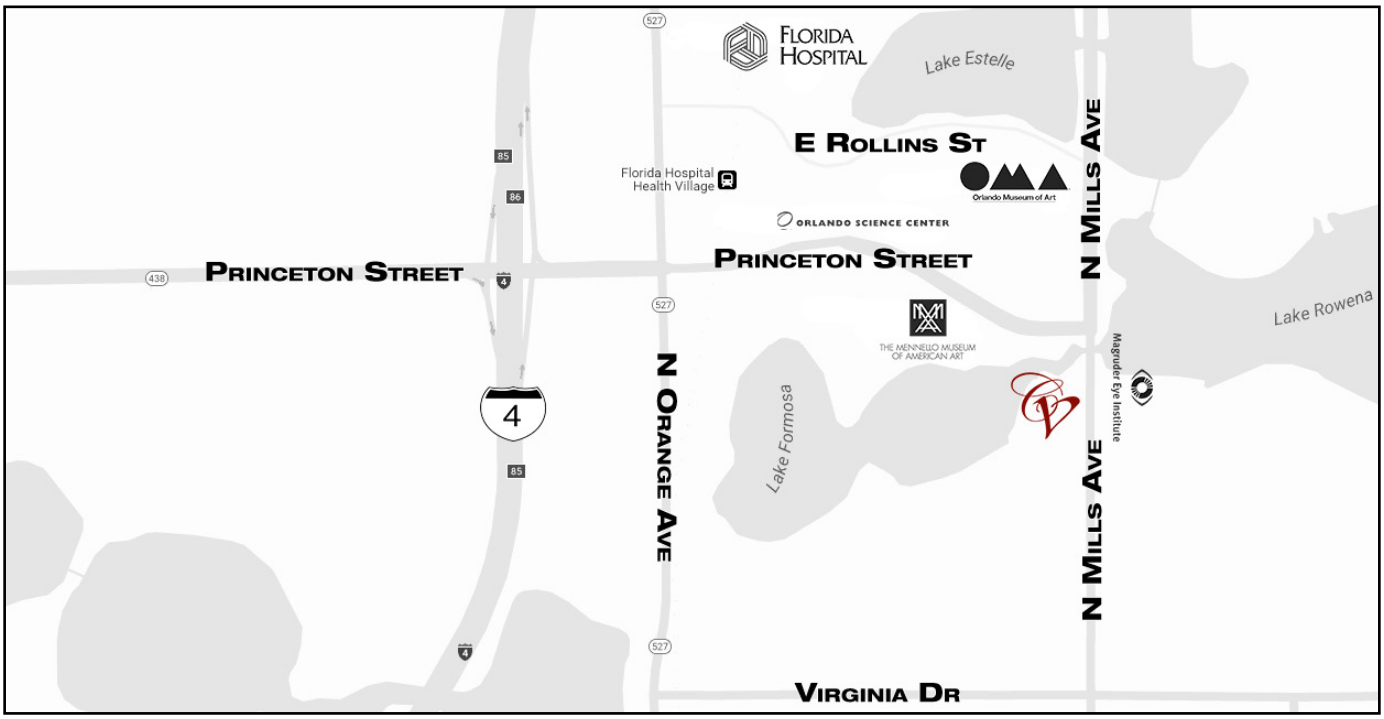
Dear Patient:

Thank you for choosing Cardiovascular Interventions. P.A. as your health care provider. Welcome to our practice. We look forward to providing you the best cardiac care.

Your appointment is scheduled for: _____ at _____

Please plan on arriving 30 minutes prior to your appointment time to ensure that all required paperwork is completed. Due to the complexity of your comprehensive office visit, it is reasonable to allow for up to two hours for your appointment time. In order to expedite this process, you will need to bring with you the following:

- [ ] **PLEASE NOTE: SIGNATURES ARE REQUIRED ON PAGES 2, 4, 5, 6, 7, 9, 15 & 17**
- [ ] **All enclosed forms - completed, signed and dated**
- [ ] **Your insurance card (s)**
- [ ] **Photo ID**
- [ ] **Your referral or authorization from your primary care physician (if needed)**
- [ ] **Medication bottles**
- [ ] **Medical records MUST be obtained a few days prior to your appointment date.** Please note that **your office visit will be rescheduled if your records have not arrived to our office by the time of your appointment.** You may request your records be sent to us by completing the enclosed "Authorization to obtain, use and/or disclose health information" form and fax, mail or hand carry it to your PCP, Specialist, Hospital or other medical provider. They will then fax or mail your records to us.



We look forward to meeting you at your first visit !

CardioVascular Interventions, P.A.

CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical and or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily accept the physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Cardiovascular Interventions, P.A. all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries, or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Cardiovascular Interventions, P.A. **Patient Initial:** _____

I request this authorization also apply to all other insurance. **Patient Initial:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

CardioVascular Interventions, P.A.

ADVANCE CARE PLANNING-PREFERENCE QUESTIONNAIRE (APC)

Name: _____ Date of Birth: _____ Today's Date: _____

Please circle the answers that apply to you. Please understand that this questionnaire is being given to all of the patients receiving care at Cardiovascular Interventions, PA. It is not being given to you because your doctor is particularly concerned about your health or well-being. Instead, all of the patients are receiving this questionnaire, because we believe that everyone should become comfortable with these topics. We hope to open discussions and or circumstances that are often left without preparation for family and caregivers for our patients.

1) **Have you completed any of the following?** (Check all that apply to you)

- ☐ Ordinary will
- ☐ Living will
- ☐ Health care proxy
- ☐ Power of attorney
- ☐ Don't know

2) **During the past 12 months, have you had a discussion with any of the following people about your preferences concerning the end of your life?** (Check all that apply to you)

- ☐ Specialist doctor
- ☐ Regular doctor
- ☐ Social worker
- ☐ Nurse or other staff person
- ☐ Family member or my health care proxy
- ☐ Friend
- ☐ Spiritual advisor
- ☐ Some other person
- ☐ I have not had a discussion about these matters during the last 12 months

3) **As you probably know, there are a number of things doctors can do to try to revive someone, whose heart has stopped beating, which usually includes a machine to help breathing. Thinking of your current condition, what would you want your doctor to do it your heart ever stops beating? Would you want your doctors to try to revive you, or would you want your doctors not to try to revive you?** (Check your choice)

- ☐ Revive me, including, the use of a breathing machine
- ☐ Allow me to go — do not try to restart my heart or use a breathing machine
- ☐ Don't know

4) **If you had to make a choice at this time, would you prefer a course of treatment that focuses on extending life as much as possible, even if it means having more pain and discomfort, or would you want a plan of care that focuses on relieving pain and discomfort as much as possible, even if that means not living as long?** (Check your choice)

- ☐ Extend life as much as possible
- ☐ Relieve pain or discomfort as much as possible
- ☐ Don't know

5) **We realize that many people are in excellent health, lead happy and productive lives, and may feel that the above questions are not relevant to their present situation. We would still like to hear your opinion about these matters. Please write here anything that you would like us to know:**

Thank you for participating

CardioVascular Interventions, P.A.

RELEASE RECORD

Medicare Benefits to Provider, Physicians and Patient:

I certify that the information given by me in applying for payment under file XVIII of the social security act is correct. I authorize any holder of medical information or other information or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment.

Authorization for Medical and Diagnostic Treatment:

I, the undersigned, as the patient or his/her authorized representative, hereby authorize Cardiovascular Interventions, P.A., and/or Pradip Jamnadas, M.D., their/his employees and agents, to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

Release of Medical Records:

Release of medical records and medical information; I, the undersigned, as the patient or his/her authorized representative, hereby authorize Cardiovascular Interventions, P.A. and/or its representative(s) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim.

Assignment of Insurance and Financial Responsibility:

Assignment of insurance and financial responsibility; I hereby authorize payment to Cardiovascular Interventions, P.A. for benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance. It is my responsibility to pay any deductible(s) amount or any other balance not paid by my insurance in 45 days.

I Agree:

I agree to pay Cardiovascular Interventions, P.A. any monies owed if a referral form authorizing the visit is not brought in at the time of the visit or within ten days after the visit.

The Undersigned:

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Cardiovascular Interventions, P.A. or its employees, from any and all liability which may arise from this action, whether or not foreseen at present.

Signature of Patient or Responsible Party Date

Patient's name (printed)

CardioVascular Interventions, P.A.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

Patient name: _____ Date Of Birth: _____

Social Security #: XXX—XX— _____ Phone Number: _____

_____ _____

Patient or Parent/Legal Guardian (Signature) Date

_____ _____

Parent / Legal Rep / Legal Guardian (Print if applicable) Relationship to Patient

CVI STAFF USE ONLY

I hereby authorize **Cardiovascular Interventions, P.A.** to release/obtain any and all medical records concerning my care from any physician, hospital, or other healthcare professional that has provided medical care to me in the past. I also authorize the practice to release any and all medical records concerning my care to any physician, hospital, or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, administrator, or managed Care Company.

Person or Organization: _____
(Please print)

Address: _____

City/State/Zip: _____

For the purpose of: _____

The Following information is to be disclosed: [please fax results to: (407) 894-2364]

_____ Complete Record _____ Path/ Operative Reports _____ Lab testing

_____ All Diagnostic test results _____ Consultation/ Progress Notes

CardioVascular Interventions, P.A.

HIPAA PRIVACY AUTHORIZATION FORM

I authorize Cardiovascular Interventions , P.A. & Its Physicians or Providers to use and disclose protected health information described below to

_____ (Individual seeking the information).

This authorization for release of information covers the period of healthcare from:

1. [ ] _____ to _____
2. [ ] all past, present, and future periods.

a. [ ] I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

b. [ ] I authorize the release of my complete health record with the exception of the following information:

[ ] Mental health records

[ ] Communicable diseases (including HIV and AIDS)

[ ] Alcohol/drug abuse treatment

[ ] Other (please specify): _____

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until _____ date or event at which time this authorization expires.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be base on / conditional to whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____ _____

Printed name of patient or personal representative and his or her relationship to patient | Date

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

HIPPA PRIVACY ACT PATIENT CONSENT FORM/ FAMILY MEMBERS

The Health Insurance Portability and Protection Act, H.I.P.P.A requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physicians' offices, your hospital, and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except when we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient: _____ **Patient Date of Birth:** _____

Signature of Patient or Guardian: _____ **Date:** _____

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or to request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.P.A consent is **valid up to one year**. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except when we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name _____ **Relation to Patient:** _____

2. Individual Name _____ **Relation to Patient:** _____

_____ _____

Signature of Patient or Guardian: **Date:**

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you, and that relates to your past, present, or future physical or mental health, or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay any healthcare bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. Your protected health information may be provided to a physician to whom you’ve been referred to, to ensure that the physician has the necessary information to diagnose or treat you in regards to the continuity of your care.

Payment

Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for the hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name and indicate the physician you are to be seeing. We may also call you by name in the waiting room when you are ready to be seen by the physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These

situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, Workers’ Compensation, and inmates. Required uses and disclosures: under the law, we must make disclosures to you as per Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in, for notification purposes, as described in this notice of privacy practices. You must state the specific restriction requested and to whom you want the restrictions to apply towards. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best Interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from Cardiovascular Interventions, P.A by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures Cardiovascular Interventions, P.A have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to **Cardiovascular Interventions, P.A** or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our privacy practices:

Signature: _____

Print Name: _____ Date: _____

CardioVascular Interventions, P.A.

PATIENT INFORMATION SHEET

(Please Print)

☐ New Patient
☐ Established Patient Update

Today's Date: _____

PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

May we e-mail or U.S. mail practice news and brochures to you Yes [•] / No [ ]

Sex [ ] Male [ ] Female [ ] Other

Date of Birth (mm/dd/yyyy): _____ Social Security #: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow/Widower

Spouse's Name (if applicable): _____ Spouse's DOB: _____

Spouse's Social Security #: _____

Spouse's Contact number: _____ [ ] Home [ ] Cell [ ] Office

In the event i am not available, i authorized the verbal release of my medical condition, status, and/or test results over the telephone: [ ] Both [ ] To my answering machine [ ] To the specified authorize members liste'd below:

1.) _____ 2.) _____

3.) _____ 4.) _____

EMPLOYMENT INFORMATION

Patient's Company Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Spouse/Parent Company Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

NEXT OF KIN

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

CardioVascular Interventions, P.A.

PATIENT DEMOGRAPHIC INFORMATION

PRIMARY:
Insurance Company Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Identification Number: _____ Group Number: _____

Policy Number: _____

Relationship: [ ] Self [ ] Spouse [ ] Other: _____

SECONDARY:
Insurance Company Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Identification Number: _____ Group Number: _____

Policy Number: _____

Relationship: [ ] Self [ ] Spouse [ ] Other: _____

EMPLOYMENT INFORMATION

Pharmacy Information & Phone #: _____

Did another Physician refer you? [ ] Yes [ ] No
If yes, please complete the following information so we can send a report to your referring physician.

Referring Physician Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

If you have a primary care physician OTHER than your referring physician please complete the following information so we can send a report to your primary care physician.

Referring Physician Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Would you like the report from today's appointment be sent to any physician other than those listed above? [ ] Yes [ ] No

Referring Physician Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

What is your Chief Complaint or reason for your appointment today? _____

ALLERGY HISTORY

Have you ever had an allergic reaction to any medication? **[ ] Yes [ ] No** If Yes, please list medication and the reaction.

CURRENT MEDICATIONS

Please list any medications (Prescription and nonprescription) you are currently taking,
Including vitamins and aspirin. Please use a separate sheet if necessary.

Medication	Dosage	Number taken Daily

CURRENT MEDICATIONS

System	Yes	No	Date of Result/Explain
CARDIOVASCULAR			
Coronary disease - Heart Attack - Angina			
Congestive Heart Failure			
Atrial Fibrillation			
Other Arrhythmias			
Pacemaker/ICD			
Heart Valvular disorder			
High Blood Pressure			
High Cholesterol			
Peripheral Vascular Disease			
Diabetes			
Renal Failure			
GI-Ulcer / Bleeding			
Pulmonary Disease			
Stroke/ TIA			
Sleep Disorder			
Anemia/ Cancer of Blood			
Other Cancer			
Psychiatric Care			

System	Yes	No	Date of Result/Explain
RESPIRATORY			
Breathing Problems			
Shortness of Breath			
Lung Disease			
Coughing up Blood			
Tuberculosis			
Pulmonary Embolism			

OTHER MEDICAL PROBLEMS: (PLEASE LIST ALL MEDICAL CONDITIONS NOT LISTED ABOVE)

PREVIOUS OPERATIONS/HOSPITALIZATIONS

Date	Hospital (City, St)	Problem/Operation

FAMILY HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	M ☐ F ☐	
Mother				M ☐ F ☐	
Sibling	M ☐ F ☐			M ☐ F ☐	
	M ☐ F ☐			M ☐ F ☐	
	M ☐ F ☐		Grandmother *maternal*	☐ Living	
	M ☐ F ☐		Grandfather *maternal*	☐ Living	
	M ☐ F ☐		Grandmother *paternal*	☐ Living	
	M ☐ F ☐		Grandfather *paternal*	☐ Living	

CardioVascular Interventions, P.A.

PATIENT DEMOGRAPHIC INFORMATION

Birthplace: _____ Highest degree completed in School: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow/Widower How many Children do you have: _____

Current Occupation: _____

What are your hobbies?: _____

Who currently lives at home with you? _____

Do you exercise? [ ] Yes [ ] No If yes, how much? [ ] Rarely [ ] Occasionally [ ] >3 times per wk

Do you have any Dietary Restrictions: [ ] Yes [ ] No If yes, what type: _____

TOCACCO HISTORY

Have you ever smoked cigarettes? [ ] Yes [ ] No If yes how many a day [ ] None [ ] 1/2 Packs [ ] 1 Pack [ ] > 1 Pack

If you have previously smoked, how long ago did you quit? [ ] <1 Year [ ] 1-5 Years [ ] >5 Years

How many years did/have you smoke for: _____

SUBSTANCE HISTORY

Have you had significant exposure to: [ ] Pesticides [ ] Toxic Waste [ ] None

Do you drink Alcohol? [ ] Yes [ ] No Type: _____ How much per week: _____

Have you or do you take street drugs?: [ ] Yes [ ] No If yes, state type: _____

CURRENT MEDICATIONS

Have you experienced any of the following symptoms? Please mark yes or no.

If yes, please give a brief explanation

CARDIOVASCULAR	Yes	No	Explaination
Chest Pain / Pressure / Tightness			
Irregular heart rhythm / Palpitations			
Swelling of the feet, ankles or hands			
Shortness of Breath			
Blackouts			
Dizziness			
CONSTITUTIONAL			
Good General health lately			
Recent weight changes			
Extreme fatigue			
Frequent nausea and/or vomiting			
Difficulty sleeping			
ENDOCRINE			
Heat or cold intolerance			
Excess thirst or urination			

GASTROINTESTINAL	Yes	No	Explaination
Change in appetite			
Severe heart burn			
Vomiting blood			
Frequent diarrhea			
Constipation			
Black or bloody stools			
Abdominal pain			
GENITOURINARY			
Blood in urine			
Burning with urination			
Difficult/frequent urination			
Lack of bladder control			
Sexually transmitted disease			
Change in sexual function			
HEMATOLOGY/LYMPHATIC			
Easy bruising			
Frequent bleeding			
Enlarged lymph nodes			
MUSCULOSKELETAL			
Joint/muscle stiffness or pain			
Weakness of muscles or joints			
Difficulty walking			
Back pain			
NEUROLOGICAL			
Headaches			
Numbness or tingling sensation			
Weakness or paralysis			
Convulsions or seizures			
Change in memory or concentration			
Loss or blurring of vision			
Double vision			
Blackouts or dizziness			
Memory loss or confusion			
Other neurological problems			
PSYCHIATRIC			
Nervousness			
Depression			
Other			

By Signing below you are verifying that above stated information is true.

Patient Signature: _____

FINANCIAL POLICY

Thank you for choosing **Cardiovascular Interventions, P.A.** as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

If your **insurance plan** is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Referrals and Preauthorization's

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

If your medical insurance carrier's claim is denied, you will be responsible for payment in full.

Missed Appointments

Cardiovascular Interventions, P.A. requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of $40.00.

Returned Checks

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies

Patients requesting copies of medical records will be charged:

$1 per page plus $1 search fee (if applicable)

Minors

The parent(s) or guardian(s) is responsible for full payment. A signed release to treat may be required for unaccompanied minors.

FMLA/ Disability Forms

A request form must be completely filled out (Personal Information). There is a $40 fee prior to forms being completed by providers. Turnaround time is 7 to 10 business days.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other third party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I Agree...

I agree to pay Cardiovascular Interventions, P.A. any monies owed it a referral form authorizing the visit is not brought in at the time of the visit.

The Undersigned...

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Cardiovascular Interventions, P.A. or its employees, from any and all liability which may arise from this action, whether or not foreseen at present

CARDIOVASCULAR INTERVENTIONS, P.A. RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS SITE AT ANY TIME.

Signature of Patient or Responsible Party

Date

Patient's name (Printed)