CARY CARDIOLOGY, P.A.

LOCATIONS:

Cary Office:
300 Keisler Drive, Suite 204, Cary, NC 27518-7014
Tel: 919-233-0059 Fax: 919-233-0343

Fuquay-Varina Office:
400 Attain St, Fuquay-Varina, NC 27526
Tel: 919-586-7699 Fax: 919-586-7695

Dunn Office:
145 Tilghman Drive, Suite 100, Dunn, NC 28334
Tel: 910-891-7007 Fax: 910-891-7010

Benson Office:
1 Medical Drive, Benson, NC 27504
Tel: 919-233-0059 Fax: 919-233-0343
Appointments scheduled by our Cary Office.

Welcome to Cary Cardiology!

Name_____

Has an Appointment with_____

At our _____ office

Mon Tue Wed Thurs Fri

Date _____ Arrival Time_____ AM PM

Appt. Time _____ AM PM

If you are unable to keep your appointment, please give our office 24 hours' notice. Call 919-233-0059

We thank you for choosing our practice to assist you in your healthcare needs. In order to provide you with the best experience possible, please note the following information before your visit:

- ☐ Bring your current insurance cards
- ☐ Bring your current photo I.D.
- ☐ Please complete and bring the front and back of the patient history form
- ☐ Please complete and bring the enclosed consent for treatment and consent for information release forms
- ☐ Please bring all medications that you are currently taking
- ☐ Remember to bring any applicable co-pay for your visit

We realize you have a choice in who provides your cardiac care, and thank you for choosing Cary Cardiology!

Office Place Sticker Here

CARY CARDIOLOGY, P.A.

MEDICAL HISTORY FORM (PLEASE COMPLETE ALL 3 PAGES OF THIS FORM)

Patient Name: _____ Date of Birth: _____ Primary Doctor: _____

Pharmacy: _____ Reason for Visit: _____

Communications

Home Phone: _____ Acceptable to leave message: ☐ Yes ☐ No

Cell Phone: _____ Acceptable to leave message: ☐ Yes ☐ No

Drug Allergies/Reaction/Date

You may list additional allergy information on the back of this form.

1. _____ **2.** _____ **3.** _____

Medications

Please list dosage and times per day. Use back of paper if you need to list additional medications.

1. _____ **3.** _____ **5.** _____

2. _____ **4.** _____ **6.** _____

Past Medical History

Please circle the following conditions if they apply to your medical history.

Abnormal EKG	Congestive Heart Failure	Diabetes mellitus	Kidney Disease
Aneurysm	Clotting/Bleeding Disorder	Heart Murmur	Myocardial Infarction
Arrhythmia	Congenital Heart Disease	Heart Valve Problem	Pulmonary Embolism
Asthma	COPD	Hyperlipidemia	Sleep Apnea
Atrial Fibrillation	Coronary Heart Disease	Hypertension	
Cancer	Deep Vein Thrombosis	Mitral Valve Prolapse	
Other:	_____	**Other:**	_____

Past Surgical History

Please circle the following surgeries if they apply to your history.

Ablation Procedure	CABG	Carotid Stent Placement	Pacemaker Insertion
Aneurysm Repair	Cardiac Catheterization	Coronary Angioplasty	Valve Replacement
Arterial Bypass	Carotid Endarterectomy	Coronary Stent Placement	Vein Surgery
Other:	_____	**Other:**	_____

Family History:

	Alive/ Deceased	Age/Age At Death	Arrhythmia	Clotting Disorder	Cancer	Heart Attack	Heart Disease	Heart Failure	Hyper-lipidemia	Hyper-tension	Diabetes
Mother											
Father											
Sister											
Brother											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

Adopted ☐ Yes ☐ No Family History Unknown ☐

Other Family History: _____

_____

_____

Tobacco Use

☐ Yes ☐ Never ☐ Quit Date _____

Packs per day _____ Years smoked _____

Alcohol Use

☐ No ☐ Social ☐ Frequently

Glasses of wine _____

Cans of beer _____

Drug Use

☐ Yes ☐ Never ☐ Quit

Type of Drug _____

Shots of Liquor _____

Smokeless Tobacco

☐ Yes ☐ Never

Flu Vaccination

Flu Shot ☐ Yes ☐ No Month & Year _____

Covid Vaccination

☐ Yes ☐ No Month &Year_____

Additional Drug Allergy Information

_____

_____

Additional Medications

_____

_____

_____

_____

_____

Review of Systems *(please check any of the following that you have experienced in the **last 3 weeks**.)*

Constitutional
- ☐ Changes in appetite
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Recent Weight Gain (_____ lbs)
- ☐ Recent Weight Loss (_____ lbs)

Skin/Integumentary
- ☐ Change in a wart or mole
- ☐ Rash
- ☐ Sores that won't heal

Eyes
- ☐ Difficulties with Vision
- ☐ Double Vision
- ☐ Eye Pain

Ear, Nose, Throat (ENT)
- ☐ Difficulties with Hearing
- ☐ Loss of Hearing
- ☐ Ringing in the ears
- ☐ Cold Symptoms
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Seasonal Allergies
- ☐ Snoring

Cardiovascular
- ☐ Fainting
- ☐ Irregular Heart Beat
- ☐ Swelling of Extremities
- ☐ Chest Pain
- ☐ Heart Rate is Fast
- ☐ Varicose Veins
- ☐ Calf Cramps
- ☐ Difficulty Breathing on Exertion

Gastrointestinal
- ☐ Black, tarry stool
- ☐ Bloody stools
- ☐ Constipation
- ☐ Indigestion
- ☐ Heartburn
- ☐ Vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Urinating at night
- ☐ Painful urination
- ☐ Kidney Stones
- ☐ Painful intercourse

Women:
- ☐ Last menstrual period:_____
- ☐ Menstrual irregularities

Musculoskeletal
- ☐ Joint Pain
- ☐ Muscle Pain

Respiratory
- ☐ Wheezing
- ☐ Cough

Neurological
- ☐ Numbness
- ☐ Headaches

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Substance Abuse

Endocrine
- ☐ Cold Intolerance
- ☐ Excessive Urination
- ☐ Heat Intolerance

Heme/Lymph
- ☐ Easy bruising
- ☐ Enlarged Lymph Nodes
- ☐ Bleeding disorder

List all other symptoms you are experiencing that you need to discuss:

NOTICE OF PRIVACY PRACTICES
(Revised on May 24, 2022)

Uses and Disclosures for Treatment, Payment and Health Care Operations.
Cary Cardiology, P.A. may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you. In addition, Cary Cardiology, P.A. and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. Cary Cardiology, P.A. may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide your health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. Cary Cardiology, P.A. may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, Cary Cardiology, P.A. may need to give PHI to your health plan in order to be reimbursed for the services provided to you. Cary Cardiology, P.A. may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. Cary Cardiology, P.A. may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. Cary Cardiology, P.A. may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. Cary Cardiology, P.A. may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure Cary Cardiology, P.A. is complying with all applicable laws, and to help Cary Cardiology, P.A. continue to provide health care to its patients at a high level of quality. Cary Cardiology, P.A. may also disclose PHI to other health care providers and health plans for such entity's quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

For Sharing PHI Among Cary Cardiology, P.A. And Its Medical and Allied Health Professional Staff.
Cary Cardiology, P.A. and the physicians and other health care providers who are members of the Cary Cardiology, P.A. medical staff work together in an organized health care arrangement to provide medical services to you when you are a patient at Cary Cardiology, P.A. Cary Cardiology, P.A. and the members of its medical staff will share with each other PHI that they collect from you at Cary Cardiology, P.A. as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at Cary Cardiology, P.A.

Disclosure to Health Information Exchanges.
Cary Cardiology, P.A. participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and

State Health Plans. We may also share other patient data with NC HealthConnex not paid for with state funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our office and online at NCHealthConnex.gov. You may also contact our privacy office at (919)233-0059 ext.143. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthconnex.gov/patients.

Regulatory Requirements.
Cary Cardiology, P.A. is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. Cary Cardiology, P.A. reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before Cary Cardiology, P.A. makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in the Admissions areas. You have the following rights regarding your PHI:

You may request that Cary Cardiology, P.A. restrict the use and disclosure of your PHI. Cary Cardiology, P.A. is not required to agree to any restrictions you request, but if Cary Cardiology, P.A. does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from Cary Cardiology, P.A. be made by particular means or at particular locations.

Generally, you have the right to inspect and copy your PHI that Cary Cardiology, P.A. maintains, provided that you make your request in writing to the Medical Records Custodian. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), Cary Cardiology, P.A. will inform you of the extent to which your request has or has not been granted. In some cases, Cary Cardiology, P.A. may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, Cary Cardiology, P.A. may impose a reasonable fee to cover copying, postage, and related costs. If Cary Cardiology, P.A. denies access to your PHI, it will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If Cary Cardiology, P.A. does not maintain the PHI you request and if it knows where that PHI is located, it will tell you how to redirect your request.

CARY CARDIOLOGY, P.A.

CONSENT FOR TREATMENT
ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT PRIVACY NOTICE

By signing this form, I consent to treatment and care by the physicians and healthcare providers of Cary Cardiology, PA. I understand treatment services may include but are not limited to: Lab Tests, Screening Tests, Diagnostic Tests, and Routine Exams. I understand that no promises have been made to me about the results of any treatment or services. I further understand that in order to ensure proper care, Cary Cardiology, PA may require certain periodic lab testing or follow ups prior to certain medication refills. I understand it is important to be an active participant in my healthcare.

I also authorize Cary Cardiology to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers, or others involved in processing and collection of payment for services in accordance with the HIPAA Patient Confidentiality Act of 1996.

I understand that I am financially responsible for, agree to pay, and guarantee payment for any and all services rendered by Cary Cardiology, PA physicians and healthcare professionals involved in providing my treatment or consultation, even if such treatment is not covered by insurance. I understand that my bill will be sent to the address I have provided unless I complete a request for my bill to be sent to an alternate address.

I authorize payment of any refund due for overpaid insurance benefits to be paid to the appropriate payor in accordance with my insurance policy conditions or any applicable benefit provisions where my coverages are subject to a coordination of benefits clause. If any refund is now or in the future due to me, I authorize the immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by Cary Cardiology, PA. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs including a collections fee that may be added to the account. If we have to refer collection of the balance to a lawyer, you agree to pay all the lawyers' fees that we incur, plus all the court costs. If we need to send the account balance to collections because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider. All accounts sent to a collection agency will be reported to the Credit Bureau and may be subject to a collection fee of $50.

By signing below, I am indicating that I understand and agree to the above releases, authorizations, and assignments of benefits.

Patient/Representative Signature: _____ **Date:** _____

Witness: _____

Acknowledgment of receipt of Cary Cardiology Privacy Practices. If I am a first time patient, I have a received a copy of the Cary Cardiology Privacy Practices. If I am a returning patient, I certify that I have been offered a copy of the Cary Cardiology Privacy Practices.

Patient/Representative Signature: _____ **Date:** _____

Witness: _____

Office Use:

☐ Patient unable to sign due to condition and/or level of consciousness
☐ Patient refused to sign after receiving Privacy Notice
☐ Other: _____

Place sticker here

Completed by: _____ Date: _____ Time: _____

(Rev 08.04.2022)

300 Keisler Drive | Suite 204 | Cary, N.C. 27518 | Phone 919.233.0059 | Fax 919.233.0343

CARY CARDIOLOGY, P.A.

FINANCIAL POLICY

Insurance Policies:
All copays and past due balances are expected at the time of service. If your copay is not paid at check in, we reserve the right to charge a $10.00 administrative fee.

We will, as a courtesy, file insurance claims that we participate with on your behalf. Please note that if your insurance company fails to pay your claim in a timely manner it will become your responsibility. If you fail to provide us with the correct insurance policy, and we cannot file claims due to the 180-day commercial insurance timely filing limit, these charges will be your responsibility. Secondary claims will be filed once, and we will only file to those carriers we participate with.

Self-Pay:
You will be considered a "Self-Pay" patient if you do not have insurance or carry an insurance we do not accept. Our list of accepted insurance plans can be found on our website. We offer a 50% "Prompt Pay" discount for self-pay patients with no insurance. Payment is due the date services are rendered.

NSF Checks:
A returned check fee of $25.00 will be added to your balance for NSF fees. We will no longer accept a check as payment on your account after a check is returned.

No Show Fees:
Please understand when you do not show up for your appointment, or do not provide us with 24 hours notice to cancel, it prevents another sick patient from receiving care. If you do not contact our office within 24 hours of your appointment, no show/cancellation fees will be applied to your account. You may cancel by phone or via the MyChart Patient Portal. Please refer to in office procedure documents for procedure specific cancellation fee details.

$50.00 for Office Visits / $100.00 for Diagnostic Testing Visits

Surgery Deposits:
We verify benefits for all hospital surgeries and extensive in-office procedures. You will be notified of your estimated financial responsibilities before treatment, and **payment is expected before your procedure is performed.**

Medical Records:
Medical records can be obtained for a nominal fee. Medical records to another physician are sent directly at no cost. Please see a Patient Representative for more details.

High Deductible Health Plan Deposits for Testing:
If you have a high deductible health plan, and you have not met your deductible, we will collect the below fee(s) at the time of your visit. We will then submit the remainder to your insurance company for processing. You will receive a bill in the mail for any remaining amount due.

$100.00 for Diagnostic Testing / $250.00 for Nuclear Stress Testing

I understand that I am responsible for my bill, regardless of insurance coverage. If my account should become delinquent, I agree to pay all costs incurred in collecting the account, including a reasonable attorney's fee. I hereby authorize release of my medical information to my insurance company/companies and authorize payment directly to Cary Cardiology, P.A.

Signed: _____ Date: _____

(Rev 5.24.2022)

CARY CARDIOLOGY, P.A.

ACKNOWLEDGMENT OF RESPONSIBILITY

We will file a claim directly with your insurance company for services rendered today. After the insurance company processes the claim, any remaining amount not covered by your insurance company will be your responsibility. In order for us to do this we must have the appropriate insurance information, referral, and/or authorization dated prior to your visit with Cary Cardiology, PA.

Please be aware that some insurance plans may require a referral, and/or authorization prior to your visit. If this is not received by Cary Cardiology, PA before your visit, you may be financially responsible for all or some of the charges incurred today. Your insurance is the one that requires a referral and/or authorization for medical service to be rendered not our office. Without it, all charges will be denied and payable by you.

Thank you for understanding and we encourage you to follow up with your primary care doctor directly to ensure that we have received the referral today.

By signing below, you are acknowledging you are financially responsible for any charges not covered by your insurance for your visit today.

Patient/Representative Signature: _____ Date: _____

Place Patient Sticker Here

(Rev 08.04.2022)

CARY CARDIOLOGY, P.A.

COMPOUND AUTHORIZATION

Patient Name: _____ **MRN #:** _____

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

Patient Communications

Home Phone: _____ Acceptable to leave message: ☐ Yes ☐ No

Cell Phone: _____ Acceptable to leave message: ☐ Yes ☐ No Email: _____

☐ I do not wish to designate other persons/entities to receive my health information on my behalf.

☐ I wish to grant permission to Cary Cardiology, PA to release the below checked information to the persons/entities indicated below.

☐ Spouse/Significant Other (please provide names):_____

☐ Financial/billing information **Communication:** Home Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Medical information as follows: Cell Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Labs ☐ Diagnostic Tests ☐ Appointments ☐ General medical information/condition

☐ Parent/Family Member/Other (please provide name/relationship):_____ _____

_____ _____ _____

☐ Financial/billing information **Communication:** Home Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Medical information as follows: Cell Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Labs ☐ Diagnostic Tests ☐ Appointments ☐ General medical information/condition

☐ Employer/Workers'Compensation(please provide name):_____

☐ Information about return to work and/or work restrictions, and any absences that result from appointments.

Contact Information: Phone: _____ Fax: _____

☐ School (please provide name):_____

☐ Information about any absences that result from appointments

☐ Activity Restrictions

Contact Information: Phone: _____ Fax: _____

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that the information has already been released pursuant to this authorization. Otherwise, this authorization will continue to be valid for one year.

Patient/ Represantative Signature: _____ **Date** _____

Witness: _____ ☐ Patient unable to sign

Revocation/Amendment Name/Signature: _____ **Date:** _____

(Rev 08.04.2022)

CARY CARDIOLOGY, P.A.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **MRN #:** _____

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

Daytime Phone: _____

Please indicate the reason for this request: ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal Use ☐ Other: _____

Information requested:

☐ Discharge summary ☐ History & Physical Examination ☐ Emergency Room Record

☐ Lab Report ☐ X-Ray Report ☐ Operative Report/Procedure Note

☐ Pathology Report ☐ Office Note ☐ Immunization/Vaccination Records

☐ Other: _____

Date of Encounter: _____ ☐ Obtain Rec's From_____☐ Send Rec's To_____

☐ Paper Copy ☐ CD

☐ Pick Up Name of Person to pick up information: _____

☐ Mail Mailing Address: _____

_____

☐ Fax (include area code)_____ ☐Email: _____

I understand that I may cancel or revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I chose to revoke this authorization, I must do so in writing. Unless otherwise revoked, this request will remain in effect for one year and will expire one year after the date signed.

By signing below, I am authorizing Cary Cardiology to obtain any records necessary for continuity of my medical care from any of my medical providers.

Patient/Representative Signature: _____ **Date:** _____

Office Use Only: Medical Records Representative:_____☐ Request initiated Date:_____ ☐ Completed Date:_____

Place Sticker Here

(Rev 08.04.2022)

300 Keisler Drive | Suite 204 | Cary, N.C. 27518 | Phone 919.233.0059 | Fax 919.233.0343

CARY CARDIOLOGY, P.A.

Vein Institute

A few questions for our Vein Team:

1. Do you have bulging or varicose veins? ☐Yes ☐No
   - *Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneath the skin's surface.*
2. Do your leg(s) ever feel heavy, tired, restless, or achy---especially at the end of the day? ☐Yes ☐No
3. Do your legs swell at the end of the day? ☐Yes ☐No
4. Have you ever had a thrombus or blood clot in your leg(s)? ☐Yes ☐No
   - *Was it a deep vein thrombosis (DVT)?* ☐Yes ☐No
5. Is the skin below your knees darker or hard? ☐Yes ☐No
6. Have you ever had an ulcer or open sore on your lower leg? ☐Yes ☐No
7. Have you ever worn or been advised to wear compression stockings? ☐Yes ☐No
8. Have you ever had any treatments or procedures for vein problems? ☐Yes ☐No
   - *If so, what were they?* _____
9. Do you frequently stand for long periods of time, such as at work? ☐Yes ☐No
10. Do you frequently engage in heavy lifting? ☐Yes ☐No
11. Has anyone in your blood-related family (i.e. siblings, parents, grandparents) ever had varicose veins or have been diagnosed with CVI or venous reflux? ☐Yes ☐No
12. Have you had an allergic reaction to a cyanoacrylate adhesive (strong fast-acting adhesive)? ☐Yes ☐No
13. How did you hear about us? (circle one) Website Search Friend/Family Physician Referral Social Media

Patient Name _____

For Office Use Only:

Vein Consult Yes No Appt Date:_____

Patient Label