Patient Information

Today's Date: _____

Name (Last) _____ (First) _____ (Middle)_____

DOB: _____ Sex: _____ Marital Status: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

□ I would like to receive text reminders of my upcoming appointments

Email: _____

Address: _____

City/State/Zip: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Employer: _____ Phone: _____

Employer Address:_____

Emergency Contact: _____Relationship: _____Phone: _____

Pharmacy: _____ Phone: _____

Primary Insurance

Name of Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ *DOB:* _____

Relation to Patient: _____ *Social Security Number:* _____

Secondary Insurance

Name of Insurance: _____

ID#: _____ Policy #: _____

Policy Holder's Name: _____ *DOB:* _____

Relation to Patient: _____ *Social Security Number:* _____

Assignment and Release

- I hereby authorize AZ Heart Rhythm Center to bill my insurance carrier and assign benefits to be paid directly to the physician(s) at AZ Heart Rhythm Center.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process any claims.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.

Signed: _____ Date: _____

New Patient Health Questionnaire

Todays Date:_____

NAME: _____**Date of Birth**:_____

Primary Care Physician (PCP): _____ Office Phone:_____

Referring Physician (if different from PCP): _____ Office Phone:_____

Please answer the questions below that apply to your problem:

Why are you here today (problem)? _____
(i.e. chest pain, shortness of breath, heart racing, passing out, etc.)

What causes it: _____
(i.e. walking, exercise, stress, eating, etc.)

When did it start: _____ Severity: _____
(Approximate Date) (Scale of 1-10; 10 being most severe)

Location: _____ Character: _____
(Where on your body) (i.e. sharp, dull, aching, pressure, racing, etc.)

Duration: _____ How often: _____
(Amount of time-minutes/hours it lasts) (# of times day/week/month)

Modifying factors: _____
(What makes it worse and what makes it better)

Other Cardiac Symptoms: (Please check if present)

☐ Chest pain/Pressure	☐ Waking from Sleep w/ SOB	☐ Swelling of ankles/legs	☐ Palpitations/Skipping Heart
☐ Short of Breath (SOB)	☐ SOB while lying flat	☐ Calf/Leg Pain	☐ Racing or Pounding Heart
☐ TIA/CVA	☐ Syncope / Fainting	☐ Falls	

Have you seen another Physician in regard to this problem? If yes, whom?_____
When (approximate date)? _____

Have you ever been to a Cardiologist before? If yes, when (approximate date)?_____
Why? _____
Whom? / Location of office (city/state)? _____

Do you have any medical records that may assist us? No / Yes
Do you have any recent lab work in past 6months? No / Yes

Past Cardiovascular History:

Do you or have you had any of the following? Please check if YES. (**Risk Factors in Bold**)

- ☐ Abnormal EKG
- ☐ Aortic Aneurysm/Dissection
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Cardiac Bypass Surgery (CABG)
- ☐ Cardiomyopathy
- ☐ Congenital Heart Disease (childhood)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Blocked Arteries)
- ☐ Coronary Stent (PCI)
- ☐ Deep Vein Thrombosis/DVT (leg blood clot)
- ☐ Valve Stenosis (tight valve)
- ☐ Valve Regurgitation (leaky valve)
- ☐ Ventricular Septal Defect (VSD)
- ☐ **Hypotension (low blood pressure)**
- ☐ **Hypertension (high blood pressure)**
- ☐ Murmur (extra heart sound)
- ☐ Pacemaker/ICD (defibrillator) CRT
- ☐ Pericarditis
- ☐ Pulmonary Embolism (lung blood clot)
- ☐ Pulmonary Hypertension
- ☐ Rheumatic Heart Disease
- ☐ Stroke/ Cerebrovascular disease
- ☐ **Diabetes Mellitus (type I or type II)**
- ☐ Heart Attack
- ☐ Vascular Surgery
- ☐ Heart Surgery (Any other not listed i.e valve)

ANSWER IF APPLICABLE: (Please circle answer)

Past Cardiac Testing History	NO/YES	Date	Normal/Abnormal
24 hour Rhythm Monitor (Holter)	**N / Y**		**NL / ABN**
Event Monitor	**N / Y**		**NL / ABN**
Echocardiogram	**N / Y**		**NL / ABN**
Stress Test	**N / Y**		**NL / ABN**
Stress Echocardiogram	**N / Y**		**NL / ABN**
Stress Nuclear Test	**N / Y**		**NL / ABN**
Cardiac Catheterization	**N / Y**		**NL / ABN**
Electron Beam CT/Calcium Score	**N / Y**		**NL / ABN**
OTHER:			

MEDICATIONS: List ALL medications that you are currently taking including non-prescription medications & Herbal remedies.

MEDICATION	DOSE	HOW OFTEN?	APPROXIMATE START DATE (MONTH AND YEAR)

ALLERGIES OR SENSITIVIY TO MEDICATIONS:

Allergic to:	Severity:

GENERAL PAST MEDICAL HISTORY:

Please Check if Yes.

☐ Asthma	☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Autoimmune Disorder	☐ Bleeding problems	☐ Cancer	☐ COPD/Lung disease
☐ Depression	☐ Gallbladder Stones/Disease	☐ GI Bleed/Peptic ulcer disease/AVM	
☐ Gout	☐ Hemorrhoids	☐ Hepatitis (A or B or C)	☐ HIV/AIDs
☐ Thyroid Disease	☐ Kidney Disease	☐ Liver Disease	☐ Neuropathy
☐ Obesity	☐ Osteoporosis	☐ Seizures	☐ Sleep apnea
☐ Smoking (Tobacco)	☐ Varicose Veins		
Females only:			
☐ Gestational Diabetes	☐ Menopause	☐ Pregnancy Induced Hypertension	☐ Preeclampsia/Eclampsia
Males Only:			
☐ Erectile Dysfunction (ED)	☐ Enlarged Prostate (Reduced Urine flow)/BPH		

PAST SURGICAL HISTORY (MAJOR ONLY: Cardiovascular and General)

Year	Major Surgery

IF FEMALE:

Hysterectomy NO/YES	Ovaries Removed NO/YES	# of Pregnancies:

FAMILY HISTORY: Questions will pertain to **only** first-degree relatives (i.e. parents, brothers/sisters, and children) in your family. Questions will also pertain to age limits: Males 55 or younger, and females 65 or younger. Do any of your first-degree relatives have any of the following? Please circle **Y / N** to the questions listed below, and if yes please explain.

1. Premature heart blockage or heart attack? **Y / N** _____
2. Heart failure or Cardiomyopathy? **Y / N** _____
3. Sudden cardiac death or unexplained death? **Y / N** _____
4. Abnormal heart rhythm? **Y / N** _____
5. Any other cardiac disease not yet mentioned? **Y / N** _____
6. Is your father alive? **Y / N** Age: _____ If deceased, at what age? ____ Cause if known:_____
7. Is your mother alive? **Y / N** Age: ____ If deceased, at what age? ____ Cause if known:_____

SOCIAL HISTORY:

1. What is your occupation? _____
2. Marital Status:_____ If children, how many? _____

3. Do you or have you ever smoked (cigarette, cigar or pipe)? **Y / N** If so how long (yrs)?_____
   How many per/day? _____ If you quit, when? _____
   Non-smoking Tobacco (Chew/Snuff)? _____

4. Do you use Alcohol? **Y / N** If yes, type and how much/frequency? (Drinks/wk) 0-5___ 6-10___ >10____

5. Have you ever used illicit drugs (type/how long)? **Y / N**_____

6. Do you exercise? **Y / N** Type of exercise: _____
   How often: (Sessions/Week) 0-3: _____ 4-7: _____
   How long are your exercise sessions? 10-30mins_____ 31-60mins _____ >60mins

7. Any special diet? (i.e. Dash, Adkins, low-fat, high-protein, low-salt ,etc.) _____
8. Do you add salt to food? **Y / N** Daily Caffeine? **Y / N** Daily Soft Drinks/ Sodas? **Y / N**

REVIEW OF SYSTEMS: Please check the following symptoms that have occurred within the **last 30 days**. (Leave blank if negative)

☐ Abdominal Pain	☐ Fatigue	☐ Recurrent Headaches
☐ Anxiety	☐ Fevers/Chills	☐ Ringing in Ear/Tinnitus
☐ Balance Problems/Falls	☐ Heartburn	☐ Seizures
☐ Blood in Stool/Black Stool	☐ Muscle pain/weakness	☐ Sinus Problems
☐ Blood in urine	☐ Nausea	☐ Slurred Speech
☐ Blurred Vision/Double vision	☐ Nose/Gum Bleeding	☐ Snoring
☐ Clotting Disorder	☐ Poor Dental Health	☐ Urination at night
☐ Depression	☐ Rash	☐ Wheezing
☐ Excessive Bruising	☐ Recent Weight Loss/Gain	☐ Are you pregnant?

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office, AZ Heart Rhythm Center, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
[The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of AZ Heart Rhythm Center reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of AZ Heart Rhythm Center may call my home or other alternative location and leave a message on voicemail or in person, in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including testing and laboratory results.

With this consent, the office of AZ Heart Rhythm Center may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of AZ Heart Rhythm Center may e-mail to my home or other alternative location on any occasion that assists the practice in carrying out TPO, such as, appointment reminders and patient statements. I have the right to request that the office of AZ Heart Rhythm Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of AZ Heart Rhythm Center may use and disclose my PHI to carry out TPO. I may revoke my consent in **writing, except for services already rendered, according to my prior consent.** If I do not sign this consent, or later revoke it, the office of AZ Heart Rhythm Center may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Printed Name

_____ _____

Print Name of Patient or Legal Guardian Date

FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions. **How may I pay?**

We accept payment by cash, check, VISA, MasterCard, Discover, and American Express.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors, explained below.

If you have	***You are responsible for .....***	***Our staff will .....***
Commercial Insurance Medicare Medicare Replacement	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the service's you receive are covered by the plan: All applicable copays and deductibles are requested at the time of visit	File an insurance claim on your behalf.
	If the service's you receive are not covered by the plan: Payment in full is requested at time of visit.	
HMO with which we are not contracted and are not applying for	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non-covered services-at the time of the visit.	File an insurance claim on your behalf.
No Insurance	Payment in full required at the time of service.	

FINANCIAL PAYMENT POLICY CONTINUED

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating outpatient facilities and laboratories. For services rendered in our office and outpatient facilities please note that you may also receive bills from other non-AZ Heart Rhythm Center entities for services rendered in conjunction with your care (i.e, laboratory services, hospital services).

Any patient who is seen and fails to notify our office of any changes in their insurance, that in turn deems their services as non-covered, will be billed directly for these charges. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D at every office visit. We understand that filling out forms is at times tedious; we do our best to simplify this process.

Co-pays are required at the time of the visit.

Check Policy
We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a $35 service fee plus the amount of the original check. You may be required to make future payments using cash, credit card or money order.

No Show Policy/ Late Cancellation Policy
Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a $35-$250 for no-show/late cancellation fee. The fees for the most common appointments are listed below:

Appointment Type	Fees
Office Visit	$50
Surgery- Hospital procedure & Nuclear Testing	$250

This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following 3 No Shows.

Application/ Form Completion Fees
A prepayment fee up to $35 must be paid in full for forms and applications completion such as school physical, sport physical, disability application, and others that do not require you to come to the office.

Medical Record Fees
Charges for Medical Records copies will be determined in accordance with the current State of Arizona Office of Planning and Budget published rates. Minimum costs are approximately **$25.00** as a base fee in addition to a **per page cost of $0.10.**

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and coinsurance amounts, are my responsibility.

_____ _____ _____

Date Signature Printed Name

Permission of Release of Records

Date: _____

I _____, give permission for the following individuals
(Name of Patient)
to obtain copies of my medical records and/or any medical information pertaining to my care at Arizona Heart Rhythm Center.

Name	Relationship	Phone number

Patient's Printed Name: _____ Patient's Date of Birth: _____

Patient's Signature: _____

Guardian's Signature: _____