Phoenix
Heart | Vein | Vascular

# Patient Data Form

| LAST NAME | FIRST | MI | SEX | DATE OF BIRTH | MARITAL STATUS |
|---|---|---|---|---|---|
| | | | | | |
| MAILING ADDRESS | CITY | STATE | ZIP | HOME PHONE | CELL PHONE |
| | | | | | |

| EMPLOYER | OCCUPATION | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |
| RACE | ETHNICITY | EMAIL |
| | | |

| PARIMARY CARE PHYSICIAN | PRIMARY CARE PHYSICIAN PHONE NUMBER |
|---|---|
| | |

## In Case of Emergency

| NAME | RELATIONSHIP |
|---|---|
| | |

| MAILING ADDRESS | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|
| | | | | |

## Insurance Information

| PRIMARY INSURANCE INFORMATION | GROUP NAME OR # | POLICY NUMBER |
|---|---|---|
| | | |

| INSURANCE ADDRESS / PO BOX | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| | | | | |

| POLICY HOLDER'S NAME | POLICY HOLDER'S SS# | DATE OF BIRTH | PREFERRED PHONE |
|---|---|---|---|
| | | | |

| SECONDARY INSURANCE INFORMATION | GROUP NAME OR # | POLICY NUMBER |
|---|---|---|
| | | |

| INSURANCE ADDRESS / PO BOX | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|
| | | | | |

| POLICY HOLDER'S NAME | POLICY HOLDER'S SS# | DATE OF BIRTH | PREFERRED PHONE |
|---|---|---|---|
| | | | |

## Responsible Party (if under 18 years old)

| RESPONSIBLE PARTY | DATE OF BIRTH | RELATIONSHIP |
|---|---|---|
| | | |

| MAILING ADDRESS | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|
| | | | | |

| EMPLOYER NAME | OCCUPATION |
|---|---|
| | |

**FAMILY HISTORY**

[ ] Diabetes
[ ] Heart Attack
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke

**PERSONAL HISTORY**

Have you had your annual wellness check/followup in the last 12 months?
[ ] Yes
[ ] No

[ ] AIDS/HIV
[ ] Asthma
[ ] Cancer
[ ] Congestive Heart Failure
[ ] Diabetes
[ ] Emphysema/COPD (Lung Disease)
[ ] Gout
[ ] Heart Attack If yes, when?
[ ] Heart Murmur
[ ] Hiatal Hernia/Reflux
[ ] High Blood Pressure
If yes, how is it treated?
[ ] High Cholesterol or Triglycerides
If yes, how is it treated?

**Have you had any of the following procedures? If so, when/where?**

[ ] Bruise or Bleed Easily
[ ] Cough
[ ] Chest Pain/Pressure/Discomfort
[ ] Dizziness
[ ] Edema (Swollen legs, ankle or feet)
[ ] Fatigue
[ ] Heartburn
[ ] Irregular Heart Beats or Palpitations
[ ] Kidney/Urinary Problems
[ ] Leg Pain when Walking
[ ] Nausea/Vomitting/Abdominal Discomfort
[ ] Peripheral Vascular Disease
[ ] Rheumatic Fever
[ ] Seizures
[ ] Shortness of Breath
[ ] Sleep Disorder
[ ] Stroke If yes, when?
[ ] Thyroid Disorder
[ ] Ulcers

**SOCIAL HISTORY**

Smoking?
[ ] Yes
[ ] No
If yes, how many per day?
If you quit, when?

Alcoholic Beverages?
[ ] Yes
[ ] No
If yes, how much per day?

Caffeinated Beverages?
[ ] Yes
[ ] No
If yes, how much per day?

Exercise?
[ ] Yes
[ ] No
If yes, how often and what type?

**Are you allergic to any medications?**
[ ] Yes
[ ] No
If yes, please list below:

**WOMEN ONLY**

Do you take oral contraceptives?
[ ] Yes
[ ] No

Are you pregnant?
[ ] Yes
[ ] No

Planning to become pregnant?
[ ] Yes
[ ] No

Post-Menopausal?
[ ] Yes
[ ] No

Hystorectomy?
[ ] Yes
[ ] No
If yes, when?

| **Have you had any of the following procedures? If so, when/where?** | **MEN ONLY**<br>Prostate Problems? |
|---|---|
| [ ] Angiopasty/Stent<br>[ ] Heart/Blood Vessel Surgery<br>[ ] AHeart Catheterization<br>[ ] Heart Valve Replacement<br>[ ] Pacemaker/ICD<br>[ ] Treadmill/Exercise Test<br>[ ] Cardiac Ultrasound | [ ] Yes<br>[ ] No |

# Hospitalization Information

To ensure we have accurate records for your visit today, please clearly complete this form. When finished, please return to the front office. Thank you.

**Previous Hospitalizations:**

Have you been a patient an any hospital within the last six (6) months?
[ ] Yes
[ ] No

If yes, which hospital for the **first** occurence:

Approximate dates of hospitalization:

FROM: TO:

Which hospital for the **second** occurence:

Approximate dates of hospitalization:

FROM: TO:

Which hospital for the **third** occurence:

Approximate dates of hospitalization:

FROM: TO:

# Venous Disease Questionnaire

Do you have family members with Venous Disease?
[ ] Yes
[ ] No

Do you sit or stand for long periods of time?
[ ] Yes
[ ] No

Do your legs hurt, ache, cramp or feel heavy?
[ ] Yes
[ ] No

Do you have swelling in your legs?
[ ] Yes
[ ] No

Do you have Varicose or Spider Veins? (visible veins on your legs)
[ ] Yes
[ ] No

Do you have skin discoloration below your knees?
[ ] Yes
[ ] No

Have you ever had or currently have an ulcer on your legs?
[ ] Yes
[ ] No

Have you ever had a blood clot in your legs or Pulmonary Embolism?
[ ] Yes
[ ] No

## Quality of Sleep Assessment

Please answer the following questions to assist your physician in diagnosing the quality of your sleep:

| | |
|---|---|
| 1. Do you use a CPAP? | [ ] Yes [ ] No |
| 2. Are you aware that you snore or do others claim you snore? | [ ] Yes [ ] No |
| 3. Do you feel tired, fatigued, or sleepy during daytime? | [ ] Yes [ ] No |
| 4. Have you noticed or have others observed that you choke, gasp for air, or stop breathing during sleep? | [ ] Yes [ ] No |
| 5. Do you have high blood pressure? | [ ] Yes [ ] No |

| | |
|---|---|
| 6. Do you consider yourself to be overweight? | [ ] Yes [ ] No |
| 7. Do you wear a shirt size of large or larger due to small or medium shirt being too tight around the neck? | [ ] Yes [ ] No |
| 8. Are you male? | [ ] Yes [ ] No |
| 9. Are you over 50 years of age? | [ ] Yes [ ] No |

# Assignment of Benefits Form

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Phoenix Heart PLLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I further agree to pay all collection costs, attorney fees, and other fees that may be incurred to obtain payment for any outstanding amounts. You may be charged $25.00 for missing or canceling an appointment that was not done within 24 hours' notice. Phoenix Heart PLLC charges $50.00 for all returned checks.

# Authorization to Release Information

I hereby authorize Phoenix Heart PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical service from Phoenix Heart PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

**Patient/Responsible Party Signature: Date:**

**Witness: Date:**

# Notice of Privacy Practice

For Quality assurance purposes all calls may be monitored or recorded.

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1.To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety or another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5.If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6.To federal officials for intelligence and national security activities authorized by law.
7.To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8.For Workers Compensation and similar programs.

**Your rights regarding your health information:**

1.Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2.You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3.You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Anna Osback, Director of Revenue/HIPAA Compliance Officer. 602-298-7777 ext. 134. 5859 W. Talavi Blvd, Suite 100, Glendale, Arizona 85306.

4.You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Anna Osback, Director of Revenue/HIPAA Compliance Officer. 5859 W. Talavi Blvd, Suite 100, Glendale, Arizona 85306. 602-298-7777 ext. 134. You must provide us with a reason that supports your request for amendment.
5.Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6.Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Anna Osback, Director of Revenue/HIPAA Compliance Officer. 602-298-7777 ext. 134. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7.Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

If you have any questions regarding this notice or our health information privacy policies, please contact Anna Osback, Director of Revenue/HIPAA Compliance Officer. 602-298-7777 ext. 134.

I hereby acknowledge that I have been presented with a copy of Phoenix Heart PLLC Notice of Privacy Practices.

**Signature:** **Date:**

# (Optional) Release of Information (ROI) to Other Individual(s)

This authorization grants permission to the person named below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis and treatment plans; and have access to my financial health information.

MRN #(staff use): {{PATIENTID}}

Authorized Individual:

Relationship to patient: Telephone:

Authorized Individual:

Relationship to patient: Telephone:

Authorized Individual:

Relationship to patient: Telephone:

I hereby authorize Phoenix Heart, PLLC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named above the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying Phoenix Heart, PLLC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Phoenix Heart, PLLC prior to their receipt of the revocation.

I understand that my treatment cannot be conditioned on whether I sign this authorization.

**Patient Signature: Date:**

# Patient Consent for Use and Disclosure of Health Information

I hereby give my consent for Phoenix Heart PLLC to use and disclose protected health information about me to carry out treatment, payment, and health care operations. The Notice of Privacy Practices provided by Phoenix Heart PLLC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Phoenix Heart PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Anna Osback, Director of Revenue/HIPAA Compliance Office. 602-298-7777 ext. 134, 5859 W. Talavi Blvd. Suite 100, Glendale, Arizona 85306

With this consent, Phoenix Heart PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations: such as appointment reminders, insurance items, and any calls pertaining to my clinical care and or including laboratory test results.

With this consent, Phoenix Heart PLLC may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

I have the right to request that Phoenix Heart PLLC restrict how it uses or discloses my personal health information to carry out health care operations. 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 to allow Phoenix Heart PLLC to use and disclose my personal health information to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Phoenix Heart PLLC may decline to provide treatment to me.

**Patient/Responsible Party Signature: Date:**

**Relationship to Patient (if not patient):**

# Financial Policy and Patient Responsibility

**We are committed to providing our patients with the highest quality care.**
**Thank you for taking the time to read and understand our policy.**

**Healthcare Providers and Patients have a unique relationship with insurance carriers and different sets of responsibilities.**

**It is the Patient's Responsibility:**

**• To know their insurance policy. Patients should be aware of their benefit coverage prior to their appointment regarding such items as contracted physicians with their plan, covered and non-covered benefits, authorization requirements, deductibles, coinsurance and co-pays. We recommend you contact your carrier directly with any questions pertaining to your coverage.**
**•To obtain a referral from their Primary Care Physician (PCP) prior to receiving services. Any noncovered services are the financial responsibility of the patient.**
**•To pay their co-pay, deductible and coinsurance at the time of service when requested.**
**•To promptly pay any patient responsibility indicated by their insurance carrier.**
**•To pay any balance due as a result of non-disclosure of any health insurance coverage.**
**•To facilitate claims payment by contacting their insurance carrier when claims have not been paid.**
**•To understand that as a courtesy, we will file claims with a secondary or tertiary insurance carrier one time. Payment and/or follow up on balances due by a secondary or tertiary insurance are the patient's responsibility.**
**•To be held responsible for any return check fees.**
**•To cancel an appointment at least 24 hours in advance. Failure to give a 24-hour time notice may result in the assessment of a no-show fee: $25 for an office visit, $50 for testing.**
**•To pay a $25 administrative fee or to make an appointment with the provider, when requested by the provider, for the completion of forms such as FMLA, Disability and other forms requiring manual completion. Payment is required in advance and is not billable to your insurance carrier.**

**It is the Provider's Responsibility:**

**•To file insurance claims on the patient's behalf. We will file a claim with primary carriers. As a courtesy to our patients, secondary and tertiary claims will also be filed one time. A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.**
**•We are not responsible for providing insurance coverage and benefit information to patients. As a courtesy, our Billing Department is available to assist you with your questions.**

**Phoenix Heart, PLLC may release any information regarding my medical condition and treatment to my insurance company. I assign all insurance benefits to Phoenix Heart, PLLC. I understand I am responsible for any and all charges. I agree to pay any balance unpaid by my insurance company. This authorization will remain in effect until revoked by me in writing.**

**I have read and understand the above financial policy. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.**

**Patient Name (please print): {{PATIENTFIRSTNAME}} {{PATIENTLASTNAME}}**

**Signature: Date:**

# Notice of Health Information Practices

**You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.**

## How does Health Current help you to get better care?

**In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.**

## What health information is available through Health Current?

**The following types of health information may be available:**

- **Hospital records**
- **Radiology reports**
- **Medical history**
- **Clinic and doctor visit information**
- **Medications**
- **Health plan enrollment and eligibility**
- **Allergies**
- **Lab test results**
- **Other information helpful for your treatment**

## Who can view your health information through Health Current and when can it be shared?

**People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as**

**conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.**

**Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current. The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.**

**You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.**

**Does Health Current receive behavioral health information and if so, who can access it?**

**Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.**

**How is your health information protected?**

**Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.**

# Your Rights Regarding Secure Electronic Information Sharing

**You have the right to:**

**1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.**
**2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.**
**3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.**

**You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:**

**1.Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 daysof Health Current receiving your Opt Out Form from your healthcare provider.**
**<u>Caution:</u> If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.**
**2.If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.**
**3.If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.**

## IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.