East Valley Heart

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▼ 01 - PATIENT INFORMATION ▼

How Did You Find Us? _____

PATIENT NAME: _____
First *Middle* *Last*

PRIMARY *(AZ)* ADDRESS: _____
Street Address *City* *State* *Zip*

SECONDARY ADDRESS: _____
Street Address *City* *State* *Zip*

HOME PHONE: _____ CELL: _____

*E-MAIL: _____ PATIENT PORTAL ACCESS: Yes No (Circle One)

BIRTH DATE: ____ - ____ - ____ SOC. SEC. *(or SIN)* #: ____ - ____ - ____
Month *Day* *Year*

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown GENDER: ☐ Male ☐ Female

RACE: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Asian ☐ White/Caucasian ☐ Other Race ☐ Unknown
☐ Native Hawaiian/Pacific Islander

MARITAL STATUS: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Other Relationship

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

PHARMACY: _____

(If Patient, check here ☐ and skip to Insurance Information)

GUARANTOR NAME: _____ GENDER: ☐ Male ☐ Female
First *Middle* *Last*

BIRTH DATE: _____ RELATIONSHIP TO PATIENT: ☐ Parent ☐ Spouse ☐ Employer ☐ Child ☐ Life Partner ☐ Other _____
Month *Day* *Year*

▼ INSURANCE POLICY INFORMATION ▼

PRIMARY INSURANCE: _____ EFFECTIVE DATE: _____

POLICY ID #: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ EFFECTIVE DATE: _____

POLICY ID #: _____ GROUP NUMBER: _____

▼ INSURANCE AGREEMENT ▼

†By signing my name below, I hereby give permission to treat me and/or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have.

†I authorize the release of any medical information necessary to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

† _____ _____
PATIENT SIGNATURE DATE

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02 - PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

Do you currently have or recently have had any of the following symptoms?

CARDIOVASCULAR		
High Blood Pressure	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Chest Discomfort	☐Yes	☐No
Fluttering Feeling in Chest	☐Yes	☐No
Skipped Heartbeats	☐Yes	☐No
Swelling in Ankles/Feet	☐Yes	☐No
Varicose Veins	☐Yes	☐No

CONSTITUTIONAL		
Significant Weight Loss	☐Yes	☐No
Significant Weight Gain	☐Yes	☐No
Night Sweats	☐Yes	☐No
Unexplained Fever	☐Yes	☐No

ENDOCRINE		
Thyroid Problem	☐Yes	☐No

EAR/NOSE/MOUTH/THROAT		
Difficulty Swallowing	☐Yes	☐No
Dry, Hoarse Throat	☐Yes	☐No

EYES		
Blurred/Double Vision	☐Yes	☐No
Cataracts	☐Yes	☐No
Glaucoma	☐Yes	☐No

GASTROINTESTINAL		
Indigestion/Nausea	☐Yes	☐No
Ulcers	☐Yes	☐No
Diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Abdominal Pain	☐Yes	☐No

GENITOURINARY		
Loss of Bladder Control	☐Yes	☐No
Blood in Urine	☐Yes	☐No

HEMATOLOGY/LYMPHATIC		
Breast Masses/Lumps	☐Yes	☐No
Enlarged Lymph Nodes	☐Yes	☐No
Unexplained Bruising	☐Yes	☐No

INTEGUMENTARY		
Skin Rash	☐Yes	☐No

MUSCULOSKELETAL		
Arthritis	☐Yes	☐No
Back Pain	☐Yes	☐No
Muscle Weakness	☐Yes	☐No
Leg Pain	☐Yes	☐No

NEUROLOGICAL		
Headaches/Migraines	☐Yes	☐No
Memory Loss	☐Yes	☐No
Speech Problems	☐Yes	☐No
Dizziness/Fainting Spells	☐Yes	☐No
Stroke	☐Yes	☐No

PSYCHOLOGICAL		
Depression	☐Yes	☐No
Anxiety	☐Yes	☐No
High/Unusual Stress	☐Yes	☐No
Eating Disorder	☐Yes	☐No

RESPIRATORY		
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Chronic Cough	☐Yes	☐No
Wheezing	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
History of Tuberculosis	☐Yes	☐No
Valley Fever	☐Yes	☐No
Lung Disease	☐Yes	☐No

PATIENT NAME _____ DATE _____

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03 - PATIENT MEDICAL HISTORY

Please check all medical issues you have now or have had in the past:

Heart Disease	☐Yes	☐No	Heart Murmur	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Stroke	☐Yes	☐No
Renal/Kidney Failure	☐Yes	☐No	Diabetes	☐Yes	☐No
Lung Disease	☐Yes	☐No	Anesthesia Problems	☐Yes	☐No
Intestinal Disease	☐Yes	☐No	Valley Fever/TB	☐Yes	☐No
Thyroid Disease	☐Yes	☐No	Drug Abuse	☐Yes	☐No
Asthma/Emphysema	☐Yes	☐No	Cancer	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	*If Yes, Type of Cancer:*		

SURGICAL PROCEDURES & OPERATIONS

Please list all previous surgical procedures and operations, including dates for each:

SURGICAL PROCEDURE/OPERATIONS	DATE	RECENT HOSPITAL VISITS/IMAGES	DATE

PATIENT FAMILY HISTORY

Has anyone in your immediate, biological family ever had any of the following?

(Grandparents, Parents, Sisters and/or Brothers)

Heart Disease	☐Yes	☐No	Heart Murmur	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
High Blood Pressure	☐Yes	☐No	Stroke	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
Bleeding Disorders	☐Yes	☐No	Diabetes	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
Renal/Kidney Failure	☐Yes	☐No	Valley Fever/TB	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
Lung Disease	☐Yes	☐No	Cancer	☐Yes	☐No
If Yes, Who?			*If Yes, Who and Type of Cancer?*		

Please inform our office staff of any Living Will, Advanced Directive or Do Not Resuscitate guidelines that you may have and supply our office with a copy for your records.

PATIENT NAME _____ DATE _____

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CURRENT MEDICATION LIST

_____
Date

I, _____, understand that my doctor may rely on medication information I provide to them for my care, and that any medication misinformation can result in hospitalization or death. By signing this, I confirm the medication information I am providing here is accurate and complete. _____ *Patient Signature* _____ *Birth Date*

Are you currently enrolled with a Pain Management Service? ☐YES ☐NO	
If yes, please provide the following contact information:	
Practice Name:	
Phone:	Address:

PATIENT ALLERGIES

Drug or Medication Allergies: ☐YES ☐NO	
Allergic to Mold, Pollen, Dust: ☐YES ☐NO	

PATIENT SMOKING HISTORY

Any Past Tobacco Use? ☐YES ☐NO	If YES, Type of Tobacco Use: _____
Do You Smoke Now? ☐YES ☐NO	If YES, # Cigarettes a Day? _____
	Quit Smoking on (Date): _____

DEVICE/IMPLANT INFO	MEDICATION ALLERGIES	ALLERGIC REACTION
Type:		
Serial #:		
Implant Date:		

RX CARD INFORMATION

BIN# GROUP# PCN# PHONE#

CURRENT MEDICATIONS

MEDICATION NAME	AMOUNT/ DOSAGE	# TIMES TAKEN DAILY	ORDERING DOCTOR	START DATE

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The Epworth Sleepiness Scale

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Have you ever been diagnosed with any of the following conditions (select all that apply)?:

- O High Blood Pressure (uncontrolled)
- O Heart Failure
- O Atrial Fibrillation
- O Stroke
- O None of the above

Do you feel easily fatigued or lack stamina? O Yes O No

Have you ever received an overnight sleep study? O Yes O No

If Yes, has a physician ever diagnosed you with Central Sleep Apnea CSA or Obstructive Sleep Apnea OSA?

Type:_____When:_____Therapy Prescribed:_____ Compliant: O Yes O No

Patient Name: _____ DOB:_____ Signature:_____

Phone Number:_____

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NOTICE OF PRIVACY PRACTICES

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.

East Vallet Heart is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided.

Federal law outlines specific privacy protections and individual rights, related to the information we maintain, that identifies you as a patient. Protected information includes, demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice, outlining our legal duties and responsibilities, related to the use and disclosure of patient identifiable health information, Privacy Practices and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: we may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children or parents.

2. Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with details of your treatment, sharing our payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.

3. Health Care Operations: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.

4. Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.

5. Treatment Options: We may use your health information to inform you of treatment options or other health related services, which may be of interest to you.

6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of our office, such as after hour's telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

7. Research: We may use your information in conjunction with agents of the Practice who may be required to review your files, just as our employees are so permitted, in order to determine whether you are qualified for a research project. If you are asked to join a research project, you will be asked first to execute an authorization, granting the Practice or a research organization the right to use your protected health information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities, including reporting of certain communicable diseases.
- For workers' compensation or similar programs, as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- To health oversight agencies.
- To your employer, if we provide health care services to you at the request of the employer, whereupon, we shall provide you written notice of release of such information.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation, if you are an organ donor.
- For research purposes, under strict limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes, such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign-in sheet.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time, except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

Your health record is the physical property of practice. The information contained in it belongs to you. Below is a list of your rights regarding individually identifiable health information. All requests related to these items must be made in writing, to our privacy officer, at the address listed below. We will provide you with appropriate forms to exercise these rights. We will notify you, in writing, if your requests cannot be granted.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes, requests to restrict disclosure of our health information to only certain individuals, or entities, involved in your care, such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communication: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy of your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Practice, if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you, one time, free of charge, during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

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Financial Policy

Thank you for choosing East Valley Heart as your health care provider. We are committed to building a successful physician-patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance with any of these policies, please ask to speak with our Practice Manager.

When are payments due?

All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator.

How can I pay?

We accept payment by cash, check, VISA, and MasterCard. We will only accept post-dated checks when they are provided within an approved payment plan.

*****Do I need a referral or pre-authorization?**

If your insurance plan requires a referral authorization from your primary care physician or a pre-authorization from your insurance, you will need to contact your primary care physician or insurance company to be sure it has been obtained. If we have yet to receive authorization prior to your appointment time, we will reschedule. Failure to obtain the referral or preauthorization may result in a lower or no payment from the insurance company, and the balance will become the patient's responsibility.

*****Will you bill my insurance?**

Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company on your behalf as a courtesy to you. 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.

It is your responsibility to notify our office promptly of any patient information changes (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

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.

Any remaining patient balance after insurance payments have been received must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

Which plans do you contract with?

East Valley Heart accepts most major insurance plans. However, with frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan. It is your responsibility to verify that the physicians and the practice where you are seeking treatment are listed as authorized providers under your insurance plan. Your employer or insurance company should be able to provide a current provider listing.

What if my plan does not contract with you?

If we are not a provider under your insurance plan, you may be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

What is my financial responsibility for services?

You are responsible for all deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier for services rendered.

You will be responsible for all costs of collection including, but not limited to... attorney's fees, and collection fees, which may be added to any outstanding balance associated with your account.

If you have:

Workers' Compensation

- *If we have verified the claim with your carrier*: No payment is necessary at the time of the visit.
- *If we cannot verify your claim*: Your appointment will need to be rescheduled.

Our staff will schedule your appointment after your worker's compensation carrier calls in advance to verify the accident date, claim number, primary care physician, employer information, and referral procedures.

***The patient or the patient's legal representative is ultimately responsible for all charges for services rendered. "Non-covered" means that a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment.

Your insurance company offers appeal procedures. We will not under any circumstances falsify or change a diagnosis or symptom to convince an insurer to pay for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services if your insurance company does not. If you are unsure whether a service is covered by your plan, ultimately, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies, and your potential financial responsibility.

What if I don't have insurance?

Self-pay accounts are used for patients without insurance coverage, patients covered by insurance plans which the office does not accept, or patients without an insurance card on file with us. Liability cases may 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 in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full for services rendered at the time of service.

At the sole discretion of the practice, extended payment arrangements may be made for patients. You will be responsible to speak with a Manager 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 reasonable costs.

What if I received a bill even though I have secondary insurance?

Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

What if I need surgery?

If your physician recommends surgery, your surgery will be scheduled by your physician's staff. A staff member can answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and assist with completing all prior authorization your insurance company might require.

***Our office will require a pre-surgical deposit equal to the amount of your copayment and/or deductible to go toward your surgery copayment, deductible, or any other amount your insurance carrier deems to be the patient's responsibility. After your insurance company has processed your surgery claim, any amount remaining as a credit will be refunded to you.

You will be asked to sign an authorization for your insurance carrier to send payments directly to EVH. Any payments sent directly to the patient should be forwarded to EVH with the Explanation of Benefits, to prevent your account from being subject to collections procedures and legal action. Authorization must be signed at the initial visit, upon any changes in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that EVH is a participating provider with your insurance company. All referrals to EVH are to be obtained prior to your appointment. This will prevent your appointment from needing to be rescheduled.

Do you refer unpaid bills to collection agencies?

If a patient cannot pay the balance on their account according to the financial policy, it may be referred to an outside collection agency or an attorney for further action.

Do you charge a penalty for returned payments?

Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a $40 minimum penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?

We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

I have a hardship. How can you help me?

Some patients may accrue large balances for services provided. At the sole discretion of the practice leadership, we will work with you to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will provide you with a financial hardship packet. We may be forced to pursue collections of balances in the absence of tangible proof of hardship.

Do you charge for completing forms?

Completing disability forms, FMLA forms, and other requested supplemental insurance forms require time away from patient care and day-to-day business operations. A $75 fee per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician, and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with all pertinent information, including dates of disability and return to work. We request that you allow 5 business days for this process.

What if I missed my office visit appointment to see the physician?
We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your reserved appointment time. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled. This allows for another patient to receive care. If you miss your office visit without notification, you will be subject to a $50 No Show Fee. East Valley Heart will allow a one-time courtesy waiver per calendar year for this office visit fee. This waiver can be used as requested by the patient.

What if I missed my testing appointment in the office?
Due to the specialized nature of your testing appointment, we require 48 hours' notice for cancellations. Failure to provide this notice will be subject to a fee up to $150 dependent on testing type, as this dedicated, extended time slot cannot be easily filled.

Financial Policy Acknowledgement:

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by East Valley Heart to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate East Valley Heart to extend credit to me for services provided.

Patient or authorized representative name:_____

Patient or authorized representative signature: _____ **Date:** _____

Release of Medical Information Acknowledgement:

I authorize East Valley Heart to release any medical information necessary, including but not limited to, medical records, diagnostic reports, and billing records, to my insurance company(ies) or their representatives for the purpose of processing claims, determining benefits, and securing payment for services rendered.

Patient or authorized representative name:_____

Patient or authorized representative signature: _____ **Date:** _____