



**PATIENT INFORMATION:**

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_  
SS# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_  
Race: (optional) \_\_\_\_\_ Ethnicity: (optional) \_\_\_\_\_ Preferred language: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

**MAILING ADDRESS:**

**PHARMACY:**

Street \_\_\_\_\_ Apt# \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_  
(or closest cross streets)  
Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_  
Can we register you for our web portal? \_\_\_ Yes \_\_\_ No

**EMERGENCY CONTACT:**

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Ins: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you have a DNR in place? Yes\_\_\_ No\_\_\_ Pick one: Do Not Resuscitate: **Yes** or **No** or surrogate decision maker **Yes** or **No**. (please circle)

**I have read and acknowledge all of the above policies associated with Lifetime Heart, including:  
(INITIAL EACH BELOW)**

\_\_\_\_\_ **Authorization to Release Medical Records**  
\_\_\_\_\_ **Payment & Financial Policy**  
\_\_\_\_\_ **Privacy Notice Acknowledgement and Communication Consent**  
\_\_\_\_\_ **Appointment Cancellation and No Show Policy**

\_\_\_\_\_  
**Patient Signature/ Parent / Legally Authorized** \_\_\_\_\_ **Date**

\_\_\_\_\_  
**Patient / Parent / Legally Authorized Printed Name**



## PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### HEALTH HISTORY AND RISK FACTORS:

Have you ever experienced or have been diagnosed with:

Congestive Heart Failure (CHF)	Yes	No	
CAD (prior heart attack, bypass surgery, or stents)	Yes	No	When? _____
High Blood Pressure (hypertension)	Yes	No	
Heart Valve Disease	Yes	No	Details: _____
Peripheral Vascular/Arterial Disease (PAD)	Yes	No	Details _____
Vein disease	Yes	No	
Stroke	Yes	No	When? _____
High Cholesterol	Yes	No	When? _____
Diabetes: (Type 1 or Type 2)	Yes	No	
Cancer (Type: _____)	Yes	No	When? _____
Lung Disease (Type: _____)	Yes	No	When? _____
Bleeding or Clotting Tendencies	Yes	No	When? _____
Thyroid Disorder	Yes	No	When? _____
Other Major Illnesses: _____	Yes	No	When? _____

### SURGERIES:

What Procedure? \_\_\_\_\_ When? \_\_\_\_\_  
 What Procedure? \_\_\_\_\_ When? \_\_\_\_\_  
 What Procedure? \_\_\_\_\_ When? \_\_\_\_\_

### HOSPITALIZATIONS:

Reason \_\_\_\_\_ When? \_\_\_\_\_  
 Reason \_\_\_\_\_ When? \_\_\_\_\_

### WOMEN ONLY:

Hysterectomy? [ ] partial [ ] Full	Yes	No
Do you take Birth Control Pills?	Yes	No
Have you gone through Menopause?	Yes	No
Are you taking hormone replacements?	Yes	No

### CURRENT MEDICATION: (if you have a list, just write "see list")

Drug Name	Dosage (mg)	How many times a day?
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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**DRUG ALLERGIES:**

Drug Name	Reaction
_____	_____
_____	_____
_____	_____

Other Allergies (food, adhesive tape, iodine, contrast dye, latex, etc)  
\_\_\_\_\_

Do you smoke?	Yes	No	How Much? _____
Alcohol use?	Yes	No	How Often? _____
Drug use? _____	Yes	No	How Often? _____
Caffeine use? _____	Yes	No	How Often? _____

**FAMILY HISTORY:** Please list major medical problems in immediately family members (include age & indicate if alive or deceased):

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother or Sister \_\_\_\_\_

**PATIENT HEALTH CHECKLIST:**

**Constitutional**

- \_\_\_ Significant weight change
- \_\_\_ Night sweats
- \_\_\_ Unexplained Fever

**Eyes**

- \_\_\_ Cataracts
- \_\_\_ Blurred or double vision
- \_\_\_ Glaucoma

**ENMT**

- \_\_\_ Difficulty swallowing
- \_\_\_ Dry, Hoarse throat
- \_\_\_ Dizziness

**Cardiovascular**

- \_\_\_ Chest discomfort
- \_\_\_ Shortness of breath
- \_\_\_ Skipped beats/Palpitations
- \_\_\_ Fainting

**Respiratory**

- \_\_\_ Wheezing/Asthma
- \_\_\_ Chronic cough
- \_\_\_ Shortness of breath

**Gastrointestinal**

- \_\_\_ Indigestion/Reflux
- \_\_\_ Blood in stools
- \_\_\_ Constipation

**Musculoskeletal**

- \_\_\_ Joint pain
- \_\_\_ Back Pain
- \_\_\_ Muscle Weakness

**Integumentary**

- \_\_\_ Skin rash
- \_\_\_ Bruising
- \_\_\_ Bleeding

**Neurological**

- \_\_\_ Headache
- \_\_\_ Memory Loss
- \_\_\_ Speech problems

**Psychological**

- \_\_\_ Depression
- \_\_\_ Anxiety/Stress

**Endocrine**

- \_\_\_ Thyroid problems

**Genitourinary**

- \_\_\_ Loss of bladder control
- \_\_\_ Blood in urine



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## VASCULAR ASSESSMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### **Patient Self-Assessment**

Please take this self-assessment to see if you might be a candidate for additional screening for potential chronic venous insufficiency or peripheral arterial disease.

### **History**

- Have you ever had varicose veins?  Yes  No  
Have you ever had blood "circulation" problems?  Yes  No

### **Signs and Symptoms**

*Do you experience any of the following signs and symptoms in your **legs or ankles**?*

- Leg pain, aching or cramping?  Yes  No  
Leg pain in either your hips, thighs, or calves, when you walk?  Yes  No  
Leg or ankle swelling, especially at the end of the day?  Yes  No  
"Heaviness" in your legs?  Yes  No  
Restless legs?  Yes  No  
Skin discoloration, texture changes or hair loss in your *legs*?  Yes  No  
Do you have open wounds or sores in your *legs*?  Yes  No

### **Risk Factors; please circle:**

- |                          |                     |
|--------------------------|---------------------|
| Diabetes                 | High blood pressure |
| Smoking or tobacco use   | High cholesterol    |
| History of heart disease | History of stroke   |

\*\*\*\*\* Office Use Only Below\*\*\*\*\*

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*Positive Screening*

*Negative/Normal Screening*



**Privacy Notice Acknowledgment and Communication Consent**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
*PLEASE PRINT NAME*

**We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.**

**Can we leave detailed or confidential messages on your home phone?**

Yes \_\_\_ No \_\_\_ Home Number: \_\_\_\_\_

**Can we leave detailed or confidential messages on your cell phone?**

Yes \_\_\_ No \_\_\_ Cell Phone: \_\_\_\_\_

**Can we mail test results to your home?**

Yes \_\_\_ No \_\_\_

**How would you like to be reminded of upcoming appointments?**

Email \_\_\_\_\_ Cell/Text \_\_\_\_\_ Call/Home \_\_\_\_\_

**Exclusions/Alerts** (Please note any information that you do not want released to authorized individuals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

**SECRET QUESTION**

(i.e. Mother's maiden name, city of birth, favorite color, optional)

NAME	RELATIONSHIP	ANSWER
1)		
2)		

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Lifetime Heart & Vascular Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (please print) Date

\_\_\_\_\_  
Patient Signature or Person Authorized to Sign Relationship to Patient



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## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the Lifetime Heart & Vascular / the outside practice, to receive and/or release medical records on my behalf.

All health records in your practice, related to myself

Specific health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (480) 699-5536.

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Or as otherwise permitted by law.

\_\_\_\_\_  
Signature of Patient  
(or Personal Representative)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



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## **FINANCIAL POLICY**

Thank you for choosing us as your cardiologists. We are committed to providing you with quality and affordable health care. It is our policy that payment is due at the time of service unless other financial arrangements have been made. Please read this policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request. Please note that most forms of payment are accepted: credit card (MC, Visa, AmEx, Discover), debit card, and check (including cashier's check or money order.)

**PATIENT FINANCIAL AUTHORIZATION** Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

\_\_\_\_ **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please understand that you are responsible for payment even if you are expecting insurance to cover all or some portion of the payment. Please contact your insurance company with any questions you may have regarding your coverage.

\_\_\_\_ **Co-payments, deductibles and co-insurances:** All co-payments, deductibles and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Note that you may be charged for missed appointments (see separate Appointment Cancellation policy).

\_\_\_\_ **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Insofar as reasonably possible, you will be notified prior to the scheduled appointment if this is the case. Please remember that you are 100% responsible for all charges incurred; your physician's referral and/or our verification of your insurance benefits are not a guarantee of coverage. Some labs and other testing done at outside facilities may incur charges from those facilities.

\_\_\_\_ **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.



\_\_\_\_ **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

\_\_\_\_ **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

\_\_\_\_ **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In the event payment is not made on this account and it is referred to a collection agency I/We agree to pay the collection agency fee of \$125 in addition to the collections balance. Any arrangements/payments will need to be paid directly with/to the collection agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis only.

\_\_\_\_ **Credit Card Disputes:** If you dispute your credit card for services rendered or testing fees, this will be grounds for immediate dismissal from the practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

I have read and understand the payment policy and agree to abide by its guidelines.

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Printed Patient Name	Date
Patient Signature (or personal representative)	Relationship to Patient



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## Appointment Cancellation & No-Show Policy

At Lifetime Heart, we do our best to get our patients seen in a timely fashion. In return, we ask that you show up on time for your appointment. We do understand that at times, you may need to reschedule your office visit, test or procedure. If you cancel your appointment with sufficient notice, this allows us to fit other patients in that may need to be seen for their health concerns.

### **Effective June 1<sup>st</sup>, 2021:**

If you have an appointment for an office visit (new patient or follow-up visit), in order to avoid a cancellation charge, you must cancel your appointment at least 24 hours prior to your appointment time. Otherwise, you will incur a \$50 charge.

If you have an appoint for either a test or a procedure, in order to avoid a cancellation charge, you must cancel your appointment at least 48 hours prior to your appointment time. Otherwise, you will incur a \$250 charge.

Multiple no shows, cancellations, or excessive rescheduling of appointments can lead to a discharge from our practice.

I have read and understood, and agree to these policies.

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Print name of Patient or authorized person \_\_\_\_\_ Date \_\_\_\_\_

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Signature of Patient or authorized person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_