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:

Street _____ Apt#_____

City, State, Zip _____

Home Phone _____

Cell Phone _____

PHARMACY:

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Address: _____
(or closest cross streets)

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: _____

Subscriber ID: _____

Group Number:

Secondary Ins: _____

Subscriber ID: _____

Group Number:

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?

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

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*****

Positive Screening *Negative/Normal Screening*

3011 S. Lindsay Rd #105, Gilbert, AZ 85295 tel (480) 699-5536 fax (480) 699-9283 **www.lifetimeheart.com**

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?

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

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

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 $10 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.

____ **Payment Plan:** Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship. Call (480) 699-5536 for assistance.

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.

Printed Patient Name Date

Patient Signature(or personal representative) Relationship to Patient

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 1st, 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.

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

_____ _____

Print name of Patient or authorized person Date

_____ _____

Signature of Patient or authorized person Relationship to Patient