Phoenix Cardiovascular Institute

WELCOME TO PHOENIX CARDIOVASCULAR INSTITUTE

Patient Name:_____
First *Middle* *Last*

Address:_____
Street City State Zip

Date of Birth:_____ **Gender:** _____ **Maiden/Previous Name:**_____

Email Address: _____ **Cell Number:**_____

Home Number:_____**Preferred Method of Contact**:_____

Race

- ☐ Asian
- ☐ African American
- ☐ American Indian
- ☐ Native Hawaiian
- ☐ White
- ☐ Decline to Answer

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

Emergency Contact:_____
Name *Phone Number* *Relationship*

Is this visit related to an auto accident? Yes or No Is this visit related to a work accident? Yes or No

Reason for Being Seen Today: _____

Primary Care Provider:_____Phone Number:_____

Referring Physician:_____Phone Number:_____

***Please provide a copy of all health insurance cards to the front desk**

Primary Insurance:_____ Secondary Insurance:_____

I hereby authorize Phoenix Cardiovascular Institute to examine and treat myself or my child and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy to be paid directly to Phoenix Cardiovascular Institute. I understand that this may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders, and/or HIV status. I understand that I am responsible for the payment of any charges incurred. I accept this responsibility regardless of any reimbursement of coverage. For Medicare patients, I am responsible for the balance of any charges not paid by Medicare.

Signature of Patient:_____Date:_____

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Patient Name:_____Date of Birth:_____

ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled and shared by our practice.

I have had a chance to review Phoenix Cardiovascular Institute's Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice may not agree to my restrictions if it would affect my care. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I have read and understand the information provided above.

_____

Patient/Responsible Party Date

PATIENT COMMUNICATION PREFERENCES

From time to time while caring for our patients it may become necessary to contact you by telephone. If you are not available when we call, we would like to be able to leave a detailed telephone message (i.e., lab results) when possible. There are also times when you may want us to communicate labs, medication, treatment plans, or billing information to a trusted friend or family member. In order to protect your privacy, we need your written permission to leave detailed telephone messages on your answering machine, voicemail system, or with a person you designate. This authorization will remain in effect until you rescind it in writing.

____ **I DO CONSENT** for my healthcare provider to leave detailed telephone messages regarding my personal health information (PHI) using the following options (if no selection is made, it is understood consent to leave detailed messages has not been granted):

ACCEPTABLE CONTACT METHOD FOR MESSAGES:

_____Home Phone # _____

_____ Cell Phone # _____

_____ A Trusted Friend/Family Member Name: _____

Relationship to Patient_____Phone #_____

Patient or Responsible Party Signature:_____ Date:_____

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PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TO PHOENIX CARDIOVASCULAR INSTITUTE

Patient Name:_____Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician(s)/facility /entity listed below.
Please identify the information to be released:

_____ Release entire record -OR-_____Please Specify: _____

The identified information will be used for the following purpose:

____ Continuing care and treatment -OR-_____Other (please describe): _____

- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice.

The identified information may be used by or released to: *PHOENIX CARDIOVASCULAR INSTITUTE*

Patient Signature:_____ Date:_____

Signature of person completing this form if not patient: _____

Relationship:_____Date: _____

Witness (Practice employee):_____Date: _____

Phoenix Cardiovascular Institute

CONSENT TO TREAT/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "healthcare provider(s)" in this document means the Phoenix Cardiovascular Institute, its agents, employees, members of medical staff, their agents and employees, and other healthcare practitioners who provide care to patients.
I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. The basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. A means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy or post any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examinations, treatment, testing, and procedures as are deemed necessary in the course of my care.

RELEASE OF INFORMATION

The healthcare provider involved in my care may release information about me necessary to substantiate insurance claims.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have the policy to direct to that provides any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to health care providers are not paid after reasonable notice, that account shall be deemed delinquent, and a service charge shall be added to the amount due. In the event that I default on the payment of an account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to the Phoenix Cardiovascular Institute for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.
I understand my signature requests that payment be made, and I authorize the release of medical information necessary to pay the claim. If other health insurance is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on the approved claim form or cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of person completing this form (if not patient): _____

Relationship: _____ Date: _____

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HISTORY AND PHYSICAL FORM

Patient Name:_____ Date of Birth:_____

Allergies? _____ Latex Allergy? Yes/No

Do You Smoke? Yes/No How Much?_____

Former Smoker? Yes /No Year Quit:_____

Drink Alcohol? Yes/No Frequency?_____

Preferred Pharmacy Name:_____ Phone #_____

Medication List

Name of Medication	Dose / Frequency	Name of Medication	Dose / Frequency

Prior Surgeries, Hospitalizations, or Cardiovascular Procedures

Type of Surgery or Procedure	Hospital	Date

Family History

For Example Heart Disease, Heart Attack, Stroke, Hypertension, High Cholesterol, Coronary Artery Disease, Kidney Disease, Diabetes, Varicose Veins, Vascular Disease, Cancer, etc.

Mother		Deceased?	Yes / No
Father		Deceased?	Yes / No
Children		Deceased?	Yes / No
Siblings		Deceased?	Yes / No

Phoenix Cardiovascular Institute
132 Battlefield Crossing Ct. | Ringgold, GA 30736
706.858.3988 | phoenixcardiovascular.com

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Past Medical History (check all that apply):

Disease	Date	Disease	Date	Disease	Date	Disease	Date
Arthritis		Gall bladder		Hiatal Hernia		Pulmonary Embolism/PE	
Asthma		Glaucoma / Cataracts		High Cholesterol		Stroke/ TIA	
Cancer		Gout		Hypertension		Tuberculosis	
CHF/ CAD		Heart Attack		Kidney Disease		Thyroid	
DVT/ Deep Vein Thrombosis		Heart Failure		Obstructive Sleep Apnea		Ulcers	
Diabetes		Heart Murmur		Pacemaker		Varicose Veins	
Emphysema		Hepatitis		PAD/ Peripheral Artery Disease		Other:	

Review of Systems (check all that you are currently experiencing)

	CONSTITUTIONAL		EYES		ENT
	Fever / Chills		Blurred vision		Ear pain or hearing loss
	Generalized weakness		Loss of vision		Ulcers in mouth
	Headaches		Eye pain		Painful/difficult to swallow
	CARDIOVASCULAR		**NEUROLOGICAL**		**ENDOCRINE**
	Chest pain / SOB /Palpitations		Headaches		Diabetes
	CABG/ CAD/ CHF		Dizziness/ weakness		Thyroid
	Aneurysm		Balance/dizziness issues		Excessive hunger/thirst
	GENITOURINARY		**INTEGUMENTARY**		**PSYCHIATRIC**
	Enlarged prostate		Rash/ itching		Anxiety
	Blood in urine		Ulcers/ wounds		Depression
	Painful /frequent urination		Hair or nail changes		
	PERIPHERAL VASCULAR		**GASTROINTESTINAL**		**MUSCULOSKELETAL**
	Leg cramps/ swelling		Bloody stool / rectal bleed		Arthritis
	Foot pain at night		Nausea & vomiting		Joint pain/stiffness
	Redness/ open wounds		Weight changes		Difficulty walking
	Coldness in extremities		History of GI Bleed		
	RESPIRATORY		**ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW:**		
	Asthma				
	COPD/ emphysema				
	Obstructive Sleep Apnea/ snoring				
	SOB				

Patient Signature: _____ Date:_____

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