SCOTTSDALE CARDIOVASCULAR CENTER, P.C.

Non-invasive and Interventional Cardiology

Dear Valued Patient,

We would like to take this time to thank you for choosing Scottsdale Cardiovascular Center for your cardiac care. Enclosed you will find the paperwork necessary for your upcoming appointment. Please fill it out completely in ink and bring it with you on the day of your appointment. If you have any questions, please do not hesitate to call us at 480-945-3535.

In addition to completing these forms, we will also require the following information for your first visit:

- Insurance card and any co-payment due for visit
- Bring your prescription bottles with you
- If applicable, any referral form
- If applicable, any pertinent medical history such as lab results
- Driver's License or Other Valid Government-Issued Photo ID — this is required to prevent insurance fraud.

Please arrive at least 15 minutes early for your appointment. If you arrive late for your scheduled appointment, we may need to reschedule the appointment. This is due to the complexity of the scheduling timelines. We must have you here in case additional data needs to be retrieved from other sources.

Again thank you for choosing Scottsdale Cardiovascular Center. We look forward to meeting you!

Scottsdale Cardiovascular Center
MAIN OFFICE: 3099 Civic Center Plaza • Scottsdale, AZ 85251
SHEA OFFICE: 10250 N. 92nd Street, #202 • Scottsdale, AZ 85260
Phone: 480-945-3535 • www.scottsdalecardiocenter.com

POS Reorder # 1512415

SCOTTSDALE CARDIOVASCULAR CENTER, P.C.

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PATIENT DEMOGRAPHICS

Last Name ____________________ First Name ____________________ Middle Initial ________

SSN ____________________ DOB ____________________ Sex: M ☐ F ☐

Address: ____________________ City ____________________ ZIP ____________

Race (i.e. Caucasian/Hispanic/Asian) ____________________ Primary Language ____________________

Ethnicity (i.e. American/Mexican/German) ____________________

How may we contact you? Home Phone ☐ Cell Phone ☐ May we leave a detailed message? Y ☐ N ☐

Marital Status: S ☐ M ☐ W ☐ D ☐ Do You Smoke: Y ☐ N ☐

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

E-mail Address ____________________

Primary Care Provider ____________________ Phone ____________________

Referring Provider ____________________ Phone ____________________

Emergency Contact ____________________ Relation ____________ Phone ____________

Preferred Appointment Reminder Method: Phone ☐ Mail ☐ E-mail ☐ Text ☐

Retired: Y ☐ N ☐ Occupation or Former Occupation ____________________

Primary Insurance Name: ____________________

Primary Insurance **Holder Name:** ____________________ DOB: ____________ Relationship: ____________

Secondary Insurance Name: ____________________

Secondary Insurance **Holder Name:** ____________________ DOB: ____________ Relationship: ____________

ASSIGNMENT OF BENEFITS

I hereby authorize my benefits to be paid directly to Scottsdale Cardiovascular Center, P.C. and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

____________________ ____________________

Signature of Patient or Legal Representative Date

____________________ ____________________

Legal Representative Name Relationship to Patient

↓ **PLEASE COMPLETE REVERSE SIDE** ↓

SCOTTSDALE CARDIOVASCULAR CENTER, P.C.

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MEDICAL HISTORY

Name: ______________________ DOB: ______________ Age: __________

Occupation: ______________________ Retired Y or N   If retired, previous occupation: ______________

Marital Status: Single Married Separated Divorced Widowed   Name of Spouse: ______________

Primary Care Doctor: ______________________   Primary Care Phone #: ______________

Referring Doctor: ______________________

Reason for Visit: ____

____

Medications

Local Pharmacy Name: ______________________ Phone: ______________

Major Cross Streets: ______________________ and ______________________

Mail Order Pharmacy Name: ____

Please list the medications you are currently taking: (continue on back if space needed)

Drug	Dosage	How often per day?

Please list any Drug/Medication Allergies:

Drug	Reaction

ADDITIONAL ALLERGIES: (foods, adhesive tape, X-Ray dye, latex, etc.)   Yes ☐ No ☐

Allergy ______________________   **Reaction** ______________________

______________________   ______________________

______________________   ______________________

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MEDICAL HISTORY

Family History

Mother *Alive*(age)__________ Deceased____ Cause ______________________________

Health Problems: ______________________________

Father *Alive*(age)__________ Deceased____ Cause ______________________________

Health Problems: ______________________________

Brother *Alive*(age)__________ Deceased____ Cause ______________________________

Health Problems: ______________________________

Sister *Alive*(age)__________ Deceased____ Cause ______________________________

Health Problems: ______________________________

Child(ren) *Alive*(ages)__________________ Deceased____ Cause ______________________

Health Problems: ______________________________

Child(ren) *Alive*(ages)__________________ Deceased____ Cause ______________________

Health Problems: ______________________________

Social History

Do you have an Advanced Directive, Living Will or Healthcare Power of Attorney? Yes ☐ No ☐

Are you following a special diet? Yes ☐ No ☐ If yes, what? ______________________

Do you exercise? Yes ☐ No ☐ If yes, what and how often? ______________________

Do you Smoke? Yes ☐ No ☐ If yes, what ______________how much___________how often___________

Have you EVER smoked? Yes ☐ No ☐ If yes, what ______________how much__________Year Quit_______

Alcohol Use: Current ☐ How much and how often? ______________________

Never ☐

Former ☐ Year Quit ______________

Recreational Drug Use: Current ☐ What and how often? ______________________

Never ☐

Former ☐ Year Quit ______________

Caffeine Use: Current ☐ What and how often? ______________________

Never ☐ (coffee, tea, chocolate)

Former ☐

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Surgeries and Procedures

Heart Surgery	Yes ☐	No ☐	**Surgery**	________
(i.e. Coronary Bypass, Valve Replacement, Transplant, etc)			Facility	________
			Date	________
Vascular Surgery	Yes ☐	No ☐	**Surgery**	________
(i.e. Bypass Graft, Angioplasty, Stents, etc)			Facility	________
			Date	________
Cardiovascular Procedures/Intervention	Yes ☐	No ☐	**Surgery**	________
(i.e. Cath/Angiograms, Stents, PTCA, etc)			Facility	________
			Date	________

Do you have a Pacemaker or other cardio-assist device implant? Yes ☐ No ☐

Type: ________ Facility ________ Date ________

Any surgeries (not cardiovascular related) Yes ☐ No ☐ **Surgery** ________

Type: ________ Facility ________ Date ________

Personal History and Risk Factors

Have you been diagnosed with any of the following?

Diabetes	Yes	No	When: ________
Hypertension (High Blood Pressure)	Yes	No	When: ________
Dyslipidemia (increased lipids in blood)	Yes	No	When: ________
Peripheral Vascular Disease (PVD)	Yes	No	When: ________
Cardiomyopathy	Yes	No	When: ________
Heart Valve Disease	Yes	No	When: ________
Thyroid Disorder	Yes	No	When: ________
Bleeding Tendencies	Yes	No	When: ________
Kidney Problems	Yes	No	When: ________
Lung Disease	Yes	No	When: ________
Stroke	Yes	No	When: ________
Heart Attack (Myocardial Infarction)	Yes	No	When: ________

Family History of Heart Disease? **Yes** ☐ **No** ☐

Have you ever experienced or have been diagnosed with:

Palpitations (racing heart or skipped beats)	Yes	No	When: ________
Fainting	Yes	No	When: ________
Near-Fainting	Yes	No	When: ________
Cardiac Arrest	Yes	No	When: ________
Shortness of Breath	Yes	No	When: ________
Chest Discomfort	Yes	No	When: ________
Leg Swelling	Yes	No	When: ________
Congestive Heart Failure	Yes	No	When: ________

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Review of Systems

Are you currently experiencing any of the following symptoms? (Please check all that apply.)

Cardiac/Vascular	Chest Pains or angina	☐	Swelling of feet, ankles or hands	☐
	Palpitations	☐	Leg pain when walking	☐
	Syncope (fainting)	☐	Varicose Veins	☐
	Orthopnea	☐	Short of breath at night	☐
Constitutional	Recent weight change	☐	Fatigue	☐
Respiratory	Chronic or Frequent Cough	☐	Spitting up Blood	☐
	Shortness of Breath on Exertion	☐	Shortness of Breath at rest	☐
	Asthma or Wheezing	☐	Snoring	☐
Gastrointestinal	Loss of Appetite	☐	Nausea or Vomiting	☐
	Blood in Stool	☐	Abdominal Pain	☐
			Reflux	☐
Musculoskeletal	Joint pain	☐	Muscle weakness or pain	☐
Skin/Derm	Rash	☐	Skin sores	☐
Neurological	Frequent Headaches	☐	Lightheaded or dizzy	☐
	Seizures	☐	Stroke or TIA	☐
	Tremors	☐	Memory Loss	☐
Psychiatric	Nervousness or Anxiety	☐	Depression	☐
	Difficulty Sleeping	☐	Hallucinations	☐
Genitourinary	Blood in Urine	☐	Difficulty urinating	☐
	Painful or Burning Urination	☐	Vaginal bleeding	☐
	Use of oral contraceptive	☐	Frequent Urination	☐
			Erectile dysfunction	☐
Hematology	Anemia	☐	Bleeding or Bruising tendency	☐
HEENT	Hearing Loss	☐	Vision Changes	☐
ENDOCRINE	Goiter	☐		

Patient Signature ____________________ Date ____________________

SCOTTSDALE CARDIOVASCULAR CENTER PC

PATIENT CONSENT FOR PROTECTED HEALTH INFO
PATIENT DISCLOSURE FORM

I authorize and agree that Scottsdale Cardiovascular Center PC (SCC) may disclose my protected health information to the following persons (family, friends), each of whom is directly involved in my care.

1____________________________ 2____________________________

3____________________________ 4____________________________

E-mail address may be used:____________________________

I ACKNOWLEDGE and agree that Scottsdale Cardiovascular Center PC (SCC) may disclose my protected health information to the persons set forth, or to the email address set forth, in this form unless and until I object to such disclosures, which must be provided in writing to Scottsdale Cardiovascular Center PC (SCC). I acknowledge that Scottsdale Cardiovascular Center (SCC) may provide my health information to my other treating physicians. I further acknowledge and agree that I am not required to complete or execute this form.

DATE:________________ ____

Signature of Patient or Legal Guardian

____

Print name of Patient Date of Birth

PLEASE CHECK APPLICABLE STATEMENTS:

___ With this consent, I authorize SCC to call my home or alternative location, leave a message on voice mail, or contact me with reference to any items that assist SCC in carrying out functions of the medical practice including, but not limited to, appointment reminders, insurance queries, lab test results, prescription information and other types of examinations.

___ Alternate location and phone number:________________________________

___ With this consent, I authorize SCC to mail to my home or alternate location designated above any items that assists SCC in carrying out functions of the medical practice including, but not limited to,
Appointment reminders, patient statements, written test results and treatment instructions.

___ Alternate location and phone number:________________________________

___ With consent, I authorize SCC to transmit via a secure, encrypted internet connection, any items which assists SCC in carrying out functions of the medical practice, including but not limited to, patient care, test results, prescriptions, inter-office communication.

___ With consent, I authorize SCC to contact me via email. My e-mail address ____________________________ ________________. I understand it is my responsibility to inform SCC in writing of any changes to this information.

FINALLY, I UNDERSTAND that I have the right to request, in writing, that SCC limit or restrict its use or disclosure of my protected health information. I further understand that SCC may refuse to accept this request for limitation or restriction, if, in its professional opinion, it would compromise or limit its ability to carry out treatment, obtain payment, or perform healthcare operations. In the event SCC agrees with and accepts a restriction request regarding my protected health information, it shall be required to abide by the agreement.

BY SIGNING THIS CONSENT FORM, I consent to the above. I understand I may revoke this consent in writing at any time, however, any use or disclosure by SCC as permitted by this consent prior to my written revocation shall be deemed authorized and appropriate. I understand I may request a copy of the NOTICES OF PRIVACY PRACTICES from SCC. I understand that it is my responsibility to familiarize myself with the contents of the NOTICE. (A READ-ONLY copy is in the Lobby)

____________________________ ________________ ________________________

PATIENT/GUARDIAN SIGNATURE DATE PRINTED NAME

PATIENT COMMUNICATION FORM

By providing your contact information below, you are granting permission to be contacted via those communication channels. Your information will not be abused and will only be used to contact you regarding your care.
Example: communications include appointment reminders, reminders to schedule an appointment, important announcements regarding our Practice.

Please Print

NAME____ HOME PHONE:____________________

ADDRESS____

CELLULAR PHONE____ Please do not text me ____

EMAIL ADDRESS____

Please list any other family members and relationship for which this same contact information applies:

__________________________ __________________________

__________________________ __________________________

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone or have access to my communications my limited protected health information and to leave a message on these devices.

Signature ____Date______________

FINANCIAL POLICY

Philosophy: Whether payment is received by the patient or the health plan, we expect to be paid for services rendered. *No patient will be refused care direction, urgent care or emergency care if the patient is unable to meet the financial requirements of the practice at the time of the scheduled visit.*

Medical Insurance

It is the patient's responsibility to:

1. Notify the office <u>PRIOR to the visit</u> if there is a change in the Patient's Insurance Plan as the "new plan" may require referral or authorization *for services to be rendered.*
2. Present a valid, current insurance card at the time of service (This is a Federal Law under the "Red Flag Rule".)
3. REMIT payment at the time of service. This includes CO-PAYS, deductibles and past due balances unless the patient has been previously set-up on a payment plan with our Billing Office. (This is a Health Plan Contract Agreement)
4. It is the Patient's responsibility to verify benefits with their insurance company PRIOR to their visit.
5. It is the Patient's responsibility to obtain or confirm the referral/authorization from their Primary Care Office. If the patient fails to obtain, or we are unable to obtain for the patient, a referral required for Specialist treatment, there is a possibility the charges will be denied by the insurance company, and the patient will be held responsible for payment. We will assist with obtaining up front referral and/or authorization as needed to expedite care.
6. Non-payment of CO-PAYS at the time of service may result in a $10 administrative fee added to the patient account.
7. Repeated non-payment of CO-PAYS or Payment Plan Payments may result in Discharge from the Practice.

Self Pay/Non-Contracted Insurance Coverage : Payment in full is due at the time of service unless PRIOR ARRANGEMENTS have been made with our Billing Department. We will bill Out-Of-Network Insurances as a courtesy.

NO-SHOW/LATE Cancellation : Each patient receives telephone communication electronically as "REMINDERS" of the scheduled appointment in advance. Failure to call with 24 hours notice or reasonable short notice cancellation or no-show without notification, may result in a $50 fee assessment to the patient's account. A no-show for a **Nuclear Study** will result in a patient charge of the pharmacological agents delivered on the morning of the study. ($300-$500)

FAILURE TO RETURN HOLTER EQUIPMENT IN WORKING CONDITION will result in a repair/replacement charge applied to the patient's account. The estimate could reach full replacement fee of $4000.00. ***Handle equipment with care.***

Returned Checks : A $35.00 fee will be applied to the patient's account.

By signing this form, I hereby authorize Scottsdale Cardiovascular Center, PC to furnish the patient's insurance company(s) all medical information necessary to process any appropriate claims. I also authorize payment of medical benefits to Scottsdale Cardiovascular Center and its Providers. I understand I, or POA , or legal representative is responsible for charges regardless of insurance coverage. I agree to pay my account in accordance with the standard rates and payment terms of this office. If it is deemed necessary, in the sole discretion of this office, to refer my account to a collection agency or credit reporting agency due to nonpayment, I agree to pay any collection cost associated as a result of this action including attorney fees/claims court costs.

____ ____________________

Patient's PRINTED name SIGNATURE Today's Date