TRINITY CARDIOLOGY

Please fill out in black ink

PATIENT INFORMATION

Date Completed____________________

Patient____ ______________________________________ ________
Last Name First Name MI

Address: _____________________________________ __________________________ _______ ____________
Street City State Zip Code

Home Phone________________________ Work Phone_______________________ Cell Phone___________________

Email address__________________________ **Date of Birth** ____________ **Social Security Number** ______________

* *

Sex: Male or Female **Race:** White Black/African American Hispanic Asian Other______________
Marital Status: Single Married Divorced Widow
Employed: Full-Time Part-Time Not Employed Retired

Advanced Directives: Full Code Do Not Resuscitate (DNR) Living Will Healthcare POA

Employer: _________________________ **Occupation**____

Student: Full Time Part Time **School Attending**____

Emergency Contact: ____________________________________ _____________________________________
Contact's Name Relationship to Patient

_____________________________________ ___________________________ ___________ __________
Street Address City State Zip Code

______________________________________ _____________________________________
Home Telephone Number Work Telephone Number

Primary Care Provider ____Phone number____________________
Pharmacy Name_______________________________ Pharmacy Telephone Number__________________________

INSURANCE INFORMATION (Please provide receptionist with insurance card and photo id)

Primary Insurance __________________________ Policy Number_____________________ Group # _____________

Insured's Name _____________________________ Insured's Date of Birth _____________& SS#______________

Secondary Insurance ________________________ Policy Number _____________________ Group #______________

Insured's Name _____________________________ Insured's Date of Birth ______________& SS#______________

COMPLETE ONLY IF PATIENT IS A MINOR OR RESPONSIBLE PARTY IS SOMEONE OTHER THAN THE PATIENT

Name of Responsible Party ____________________________________Relationship to patient _____________________

Street Address __________________________________ City_________________ State _____ Zip Code ___________

Home Telephone # ____________________ Employer ______________________ Work Telephone # _______________

PATIENT CONSENT FORMS

I authorize Trinity Cardiology to submit claims to my current insurance Company and I assign all insurance benefits to Trinity Cardiology. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Trinity Cardiology may use my health care information and may disclose such information to my insurance Company for the purpose of obtaining payment for services and determining insurance benefits. I have read and understand the Financial Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I understand and approve that Trinity Cardiology may transmit my prescriptions via a secured website to my pharmacy and receive any information from pharmacies concerning my prescription history.

_____ _____

Signature of Patient or Legal Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

CONTACT PREFERENCES

I give my permission for the staff to leave messages: _____ on Home Phone _____
_____ on Cell Phone _____
_____ at Work _____

My preferred method of receiving messages is _____ Phone _____
_____Text. _____

HIPPA

I have been given a copy of the Notice of Privacy Practices which I have read and understand the use and disclosure of my medical information.

_____ _____

Signature of Patient or Legal Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

DISCLOSURE OF HEALTH INFORMATION

I authorize Trinity Cardiology to release any of my medical information to the following individual(s)

1._____ _____ _____

2._____ _____ _____

3._____ _____ _____

Name Relationship to Patient Contact #

_____ _____

Signature of Patient or Legal Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

PAST MEDICAL HISTORY

PATIENT NAME_____ **DATE OF BIRTH** _____

Past Medical History: Have you had any of the following?

High blood pressure _____ Yes _____ No
Diabetes / Sugar _____ Yes _____ No List any allergies - reaction
Heart Failure _____ Yes _____ No
Heart Murmur _____ Yes _____ No
COPD / Emphysema _____ Yes _____ No
Depression _____ Yes _____ No
Anxiety _____ Yes _____ No
Insomnia _____ Yes _____ No
GERD / Acid Reflux _____ Yes _____ No
Thyroid disease _____ Yes _____ No
Headaches / Migraines _____ Yes _____ No
Epilepsy / Seizures_____ Yes _____ No
Cancer _____ Yes _____ No

If so, what type of cancer:

Family History: Please check all that apply

	Hypertension	Diabetes	Stroke	Heart Disease	Depression/ Anxiety	Cancer
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Sibling/s	_____	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

Social History:

Do you smoke cigarettes? _____ Yes _____ No _____ Quantity
Have you smoked in the past? _____ Yes _____ No
When did you start smoking? Date: _____
When did you quit smoking? Date: _____
Do you drink alcohol? _____ Yes _____ No _____ Quantity

PATIENT NAME _____

SURGICAL HISTORY

TYPE OF SURGERY	DATE

NAME OF MEDICATION	Strength	Dose

FINANCIAL POLICY

PRACTICE FINANCIAL POLICY

An estimated payment is expected at the time of service. Payment received during check out is considered an estimated deposit, because additional charges may apply for tests, labs, or other procedures performed during your visit. You may also have additional charges after your insurance has processed the claim. You will receive a separate bill from a lab company for any labs performed by them. For your convenience we accept **cash, checks, VISA, and MasterCard**. There will be a $30.00 service charge for each returned check. We give a 20% discount for self-pay patients paying their charges **in full with cash** at the time of service.

YOUR INSURANCE

Please check with our office to see if we accept your insurance. **Your insurance coverage is a contract between you and your insurance company.** You are financially responsible for all charges. As a courtesy we will file your claim with your insurance company; however, in the event your insurance company either does not pay in a timely manner or denies paying your claim you will be billed for the charges.
In order for us to file a correct claim to your insurance, your personal and insurance information must be kept up to date. It is your responsibility to inform us of any changes in your insurance coverage.

Any balance due is your responsibility and is due upon receipt of a statement from our office. There will be a $5.00 rebilling fee for any balance not paid in full within 30 days of the statement and for co-pays not paid at the time of service. You understand that if your account is not paid it will be grounds for dismissal from our practice and will be sent to a collection agency and you agree to pay any additional collection cost.

DISABILITY PAPERWORK

Be advised that any paperwork required to be completed for disability (leave of absence, etc) will require a $30 payment at the time of request. This cost helps cover the expense of the time taken away from direct patient care.

APPOINTMENT POLICY

If you need to reschedule, please call 24 hours in advance. We strive to accommodate our patients with timely care, which is difficult to do when other patients don't show up for their appointments. If you are more than 15 minutes late or do not give the 24-hour notice, it will be considered a missed appointment. **Three missed appointments will be grounds for dismissal from our practice.** ***If you do not show up for your blood work/testing appointment, your follow-up appointment will be automatically cancelled.***

PRESCRIPTION POLICY

Please bring all medications to your first appointment and any follow-up appointment. **We highly encourage our patients to request refills during an office visit. Any refill request made other than during an office visit will incur a $5.00 charge** and requests that are approved will be called in within 48 hours. **ALL REFILL REQUEST MUST COME FROM THE PATIENT. REFILL REQUESTS ARE NOT ACCEPTED FROM PHARMACIES. Make sure you allow enough time for the refill to be called in before running out of medication.**

Medical Records

Per SC State Law (44-7-325, 44-115-80), should you require copies of your medical records, be advised that there will be a charge of $0.65 up to 30 pages, with an additional $0.50 per page beyond 30, plus a $25 Processing Fee, not to exceed $150 in total cost.

PRIVACY PRACTICE

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.

Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

a. Request Restrictions: You have a right to request restrictions on the use of your information.
b. Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice.
c. Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
d. Amend: You have the right to request that we amend your health information.
e. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
f. Request Communications of your Health Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
g. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

a. Confidentiality: Maintain the privacy of your health information.
b. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
c. Abide by the terms of this notice.
d. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
e. Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office.
We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information

a. If you have a question or would like additional information, you may contact our privacy officer.
b. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

Examples of Disclosures of Information

a. Treatment:
    1. We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.
    2. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

b. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used.

c. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

d. Business Associates: There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.

e. Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.

f. Communication with family: We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care. Our EMR system links family financial information. If you have any questions, please ask one of our staff.

g. Research: We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain written authorization from you to disclose information for other research purposes.

h. Funeral Directors: We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.

i. Organ Donation: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.

j. Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

k. Food and Drug Administration: We may disclose to the FDA health information related to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

l. Workers Compensation: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.

m. Public Health: Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.

n. Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or its agent's health information that is needed for your health or the health and safety of other individuals.

o. Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

p. Health investigation: Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.

q. Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Consent for Treatment

I voluntarily consent to medical evaluation and treatment by Todd Alderson, MD, and other appropriately authorized clinicians and staff of Trinity Cardiology. I understand that my care may include obtaining a medical history; physical examination; review of medical records; measurement of vital signs; medication management; ordering, reviewing and discussing laboratory, imaging and diagnostic studies; and other services reasonably associated with outpatient cardiovascular care. I consent to routine non-invasive diagnostic services when ordered and medically appropriate, which may include electrocardiograms (EKGs/ECGs), ambulatory cardiac monitoring, echocardiography, vascular ultrasound, pulse oximetry and other cardiovascular diagnostic testing available through the practice. I understand that this general consent does not replace a separate informed consent when one is required or appropriate for a particular procedure. I understand that medicine cannot guarantee a particular outcome and that no guarantee has been made concerning the results of my evaluation or treatment. Coordination of Care, I understand that Trinity Cardiology may use and disclose my health information for treatment, payment and health care operations and as otherwise permitted or required by law. This may include communicating with other health care professionals involved in my care, pharmacies, laboratories, hospitals, diagnostic facilities and health plans. Emergency Care, I understand that Trinity Cardiology is an outpatient medical practice and does not provide emergency medical services. I should call 911 or seek emergency medical attention for symptoms that may represent a medical emergency rather than waiting for a portal message, voicemail or routine office response.

☐ **I have read this consent, understand it, and have had an opportunity to ask questions**.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATION DATE

_____

RELATIONSHIP TO PATIENT

TRINITY CARDIOLOGY
909 WEST DEKALB ST
CAMDEN, SC 29020
P: 803-850-4564
F: 803-830-6058

Authorization to Disclose Health Information

Patient Name: _____ **DOB:** _____

I authorize Trinity Cardiology to request my health information from:

Facility Name:_____

Address: _____

Phone: _____ Fax: _____

Information to be released: (select one that applies)

- Medication List
- Procedure Records
- Laboratory Results
- X-ray and Imaging Reports
- Entire Records

Dates requesting: _____

Purpose of Release: (select one that applies)

- Continuation of Care
- Legal Representation
- Disability

I understand that the information in my health record may include information relating to sexually transmitted disease, 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.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATION **DATE**

_____

RELATIONSHIP TO PATIENT