Premier Cardiovascular Institute

Date:_____

Name: _____

Date of Birth:_____

Address:_____

City/State/Zip Code:_____

Phone Number:_____

Day Time Phone: _____

__**Yes** __**No** Results of testing may be left by message on My phone numbers listed

EMERGENCY CONTACT:_____

Relation: _____

Visit Reason:

Appt w/ Doctor _____ Diagnostic Testing

Insurance Name:

Is This New Insurance Since our last Visit:

Family Physician:

It is your responsibility to provide our office with the correct and current insurance information at every visit. You will be asked to copy your insurance at each visit. Failure to provide correct/current insurance will results in balance becoming patient responsibility.

IT IS THE PATIENT'S RESPONSIBILTY TO PROVIDE

CURRENT AND ACCURATE INSURANCE

INFORMATION FOR EACH VISIT.

(if you fail to provide correct insurance and you miss your insurance filing deadline then you will be responsible for the balance. NO EXCEPTIONS)

INSURANCE REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT.

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable or customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

You must obtain your insurance referral number from your assigned family physician for any office visits or testing. If this is not obtained prior to your visit you appointment will be rescheduled.

Verification of coverage and benefits is a courtesy (not a requirement of our contract with insurance companies) in order to provide an estimated cost of services. Guarantee of coverage and benefits is only determined by your insurance company once the claim has been submitted and processed per the disclaimer given by your insurance at the time of verification of benefits.

Signature:_____ Date:

Premier Cardiovascular Institute

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by

Premier Cardiovascular Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Premier Cardiovascular Institute**. I understand that as part of my healthcare, **Premier Cardiovascular Institute** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health professionals who contribute to my care
3. a source of information for applying my diagnosis and surgical information to my bill
4. a means by which a third party payer can verify that services billed were actually provided
5. and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Premier Cardiovascular Institute** is not required to agree to the restrictions that I may request. I have the right to revoke and/or "Opt-Out of the consent in writing, at any time, except to the extent that **Premier Cardiovascular Institute** has taken action in reliance on this consent. **Premier Cardiovascular Institute** will notify you via mail of any breaches to our PHI.

Patients will be requested to fill out and sign the Consent for Release of Information to release records to a third party and/or receive from a third party to request Protected Heath Information.

I understand I have the right to review **Premier Cardiovascular Institute**'s Notice of Privacy Practices prior to signing this document. **Premier Cardiovascular Institute**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of the protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **Premier Cardiovascular Institute**.

Premier Cardiovascular Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please disclose my Protected Health Information to:

_____

_____

Please DO NOT disclose my Protected Health Information to the following:

_____

_____

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Date of Birth**

_____

Description of Personal Representative's Authority

Premier Cardiovascular Institute

Premier Cardiovascular Institute Nurse Questionnaire

Name: _____ D.O.B.: _____ Family Physician: _____

Reason for Today's visit:_____ Recent Lab work: Date:___/___/___ Location:_____

*Were you recently in the hospital: Yes ☐ No ☐

If so, where, when & why: _____

*Any NEW medical conditions or surgeries since last visit: Yes ☐ No ☐ Details: _____
(include date/hospital/physician)

*Have you had recent cardiac stress testing or ultrasounds of your heart since you last visit: Yes ☐ No ☐ Location: _____

*Have you been diagnosed with Cancer: Yes ☐ No ☐ Type:_____ Date Diagnosed:_____

Chemo: Yes ☐ No ☐ Radiation: Yes ☐ No ☐

Additional Details:

_____

_____

_____

_____

_____

*Any new medications or changes since last visit: Yes☐ No☐

*****List CHANGES below**

Current Medications (attach list if available)	**Amount** (mg/mcg /units.etc)	**How often taken** (daily/2xday.. etc)	**Who prescribed medication and why**

*Any new medication allergies since last visit: Yes No

If yes, what: _____

Reaction:

_____

_____

****Additional medical information changes:**