Welcome to Premier Cardiovascular Institute

Patient's Name_____ Date of Birth ___/___/_____

Home Phone (_____)_____-_____ Daytime or Cell Phone(____)_____-_____

YES_____ NO_____ Premier Cardiovascular Institute may leave results or detailed mess ages

Mailing Address_____
Street or P.O. Box #

_____
City State Zip Code

Social Security # _____-____-_____ Gender M F Martial Status S M W D

Employer's Name_____

Emergency Contact Information:

_____ (____)_____-_____ (____)_____-_____
Name Home Ph # Work Ph # or Cell #

Relationship to You_____

Family Doctor_____ Referred By_____

Preferred Pharmacy_____
Name and City

INSURANCE INFORMATION

Primary Insurance :_____

Primary Insurance Id #_____ Group #_____

Policy Holder's Name : _____

Policy Holder's Date of Birth ____/____/____ SS# _____-_____-_____

Secondary Insurance: _____

Secondary Insurance Id #_____ Group #_____

Policy Holder's Name : _____ SS# _____-_____-_____

Policy Holder's Date of Birth ____/____/____

PLEASE READ AND SIGN

I hereby give consent for myself (or my child if minor) to be given medical treatment. I hereby acknowledge that I am responsible for the payment on this account. I hereby authorize that information be released to my insurance carrier and I authorize payment directly to Premier Cardiovascular Institute INC. for the medical and/or surgical benefits, If any, otherwise payable to me under my insurance. Past due balances after 60 days aresubject to collection efforts if necessary. I hereby authorize photocopies of this form to be valid as the original

Signature Date Driver's License #

Premier Cardiovascular Institute Medical Questionnaire

Name: _____**D.O.B:**_____ **Primary Care Physician:** _____

Tobacco Use

Have you ever used: □ Current □ Former □ Never
What type: □ Cigarettes □ Cigar □ Pipe □ Chewing □ Snuff □ Smokeless/Vapor
Amount per day: _____ □ Single □ Packs □ Cans
Age started: _____ and stopped: _____
Total years smoked: _____
Have you ever tried to quit: □ Yes □ No
Longest time tobacco free: _____□ Days □ Months □ Years Did you restart & why: _____
Have you been exposed to 2nd hand smoke: □ Yes □ No

Risk Factors/History

Are you a Diabetic? □ Yes □ No *** Type: □ Type 1 (Juvenile) □ Type II (Adult onset) Year diagnosed: _____
Do you have High Blood Pressure? □ Yes □ No Year diagnosed: _____
Do you have High Cholesterol? □ Yes □ No
Do you have Blockages in your Neck or leg arteries? □ Yes □ No
Do you have any known lung problems such as: □ COPD □ Asthma □ Emphysema □ No
Do you have any known kidney disease? □ Yes □ No Explain: _____
Do you have: □ Pacemaker □ Defibrillator □ No
Have you ever had a cardiac Catheterization: □ Yes □ No Date:_____/_____/_____ Stents: □ Yes □ No
Have you ever had Open Heart Surgery: □ Yes □ No Type:_____ Date:_____/_____/_____
Do you have a history of Cancer: □ Yes □ No Type:_____ Diagnosis Date: _____/_____

Family History

Any **family members** with history of **premature HEART disease *before* the age of 55**? □ Yes □ No □ Adopted
1. _____ □ Alive □ Deceased (@age)____ □ Cause of death @ age _____
2. _____ □ Alive □ Deceased (@age)____ □ Cause of death @ age _____
3. _____ □ Alive □ Deceased (@age)____ □ Cause of death @ age _____
4. _____ □ Alive □ Deceased (@age)____ □ Cause of death @ age _____
5. _____ □ Alive □ Deceased (@age)____ □ Cause of death @ age _____

Social History

Relationship Status: □Married □Single □Divorced □Engaged □Widowed □Recently Widowed □Life Partner
Children: □Yes □No # Sons: _____ # Daughters: _____
Alcohol Use: □Never □Current □Former Year Quit: _____
***Type**: □Beer □Liquor □Wine ***Amount**: _____can per day _____glasses/day _____bottle/day
***Frequency**: □Daily □Weekly □Monthly □Occasionally □ Socially □Rarely
Caffeine Intake: □Yes □No **Type:** □Coffee □Tea □Soda □Chocolate □Energy Drinks □Tablets
Activity: □Moderate □Sedentary □Vigorous □Unable to Exercise
Type of exercise**:_____Exercise frequency:** □2-3 x/wk □3-4 x/wk □Daily □Occasional
Illegal Drug Use: □Never □Current □Former Year Quit: _____
***Type/Frequency/Route used**: _____
Highest level of education: _____
Current Occupation: _____ □Retired □Disabled

Name: _____

Allergies to Medication:

□ No known drug allergy

***List drug allergy and reaction below:**

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Current Prescribed Medications

(attach list if available)

Current Medications Amount Taken How Often Taken

(include: OTC/Aspirin/Inhalers/Vitamins/etc) (Mg/Mcg/Etc) (Daily/2xday/3xday/Etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CONSENT FOR RELEASE or ACQUIRE INFORMATION

Premier Cardiovascular Institute INC.
2901 North Claybourn
Avenue, Chicago, IL 60618,
(773) 352-8881

Date:_____

1. **I hereby freely, voluntarily, authorize**
   Premier Cardiovascular Institute INC
   2901 North Claybourn Avenue,
   Chicago, IL 60618

   to **release or acquire** the following information from health record(s) of:

Patient Name:_____

Address:_____

Covering the periods of care from: _____ to _____

SSN:_____ Date of Birth:_____

2. **Information to be released:**

_____ Copy of complete health record(s)
_____ Excluding information related to HIV testing and/or results
_____ History and Physical, discharge summaries, or hospital consults
_____ EKG's, catheterizations, angioplasties, and/or bypass surgeries
_____ Stress test, echocardiograms.
_____ Other:_____

3. **Information is to be Released to or Acquire from**:_____

4. **Purpose of disclosure (Please check one)**

____ Insurance Claim _____Review by Attorney ___Continuing Care ___Care by Physician
Other (Please specify)_____

5. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. This consent will expire one year from the date signed below or as specified below. I understand that I may revoke this consent at any time. It must be revoked in writing, addressed and sent Premier Cardiovascular Institute

7. The facility, it's employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Requested Expiration Date: _____

Signed:_____
(Patient or Representative) (Date)

_____
(Relationship to Patient) (Date)

_____
(Witness) (Date)

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 providingtreatment to me, obtaining payment for my health care bills or to conduct health care operations of Premier Cardiovascular Institute. I understand thatas part of my healthcare, Premier Cardiovascular Institute originates and maintains health records describing my health history, symptoms, examinationand 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 hastaken action in reliance on this consent. Premier Cardiovascular Institute will notify you via mail of any breaches to our PHI within 3 days of incident. Patients will be requested to fill out and sign a Consent for Release of Information to release records to a third party and/or received 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 Cardiology Institute privacy notice Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosuresof 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 reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I mayobtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail orasking 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

Financial Policy

WE at Premier Cardiovascular Institute are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions
about our fees, financial policy or your responsibility.
TO assist us in establishing your Premier Cardiovascular Institute financial account please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information, and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your carrier and Premier Cardiovascular Institute with any additional information requested to complete the processing of claims
- filed on your behalf
  Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below)

UNACCOMPANIED MINORS

Minors mush have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self and/or payment at the time of service

UNINSURED PATIENTS

Any patient requiring a physician office appointment and/or diagnostic testing at our facility must pay all charges at time of service. Our office does provide a prompt pay discount on most diagnostic testing when charges are paid in full. Any patient who is uninsured is provided access to our Self Pay Payment Schedule. Upon signing below patient agrees to Premier Cardiovascular Institute Self Pay Payment Schedule.

REGARDING INSURANCE

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request in writing.

Insurance is a contract between you and your 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 and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

CONTRACTED MANAGED CARE PLANS (HMO,PPO,POS,EPO)

Each time you make an appointment with a Premier Cardiovascular Institute physician, it is your responsibility to make sure he/she is currently under
contract with your plan. Verification of your coverage and benefits is required. Often this verification requires us to share the reason for your visit with your managed care plan. ***Please plan to show your current insurance card at each visit to our office.***
If you are referred to a specialist or decide you need a specialist, you may be required per your insurance plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retroactive referrals may not be allowed on any managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full to the specialist office.

☐ I have read and understand the above terms and conditions and will verify so by giving my signature.

☐ Assignment: I hereby authorize payment directly to Premier Cardiovascular Institut or my physician. Any changes in this authorization must be received in writing 30 days of the effective date.

☐ I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

☐ I understand that as an uninsured patient I have been advised of our self pay payment schedule and all fees are due at the time of service. I agree to the payment requirements list on the Self Pay Payment Schedule.

_____ _____

Patient/ Guardian Signature Date

_____ _____

Print Name Relationship to Patient