ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Last Name:		First Name:		Mid. Initial:	
DOB:		SSN#:		Sex:	
Race:		Ethnicity:		Language:	
Home Address1:				Apt/Suite #:	
City, State, Zip:		Email:			
Home Phone:		Work Phone:		Mobile Phone:	
Preferred Phone Method:	☐ Home ☐ Work ☐ Mobile	Communicate by:	☐ Voice ☐ Email ☐ Text		

EMPLOYER INFORMATION- Employment Status: **«EmploymentStatus»**

Name: Phone#:

EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)

Name: Phone Relationship:

Name of Primary Care Provider:

PLEASE GIVE THE RECEPTIONIST YOUR CURRENT INSURANCE CARD AND YOUR DRIVERS LICENSE

PRIMARY INSURANCE

Plan/Policy Name: Group #:
Plan Phone: Subscriber DOB:
Subscriber Name: Subscriber ID:

SECONDARY INSURANCE

Plan/Policy Name: Group #:
Plan Phone: Subscriber DOB:
Subscriber Name: Subscriber ID:

PREFERRED PHARMACY

Pharmacy Name: Pharmacy Phone:

PATIENT METHOD OF DISCLOSURES

The HIPAA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

Work Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

Mobile Phone: _____
☐ Ok to leave detailed message
☐ Leave message with call back number only

☐ **Ok to mail to my home address listed above**
☐ **Ok to E-mail to «PatientEmail»**
☐ **Ok to sign up for patient portal**
☐ **I have a Power of Attorney (POA)** Name: _____
☐ **I have an Advance Directive (Living Will)**

List any Persons Allowed to obtain your Health Info on your behalf: _____

_____

I am aware that Advanced Heart uses a third-party call center to confirm appointments. I am aware that by providing my home and mobile phone number and email, I am agreeing to receive automated phone calls, text messages and email reminders. I am aware if at any time I no longer want these services, it is my responsibility to notify the office in writing or reply to third-party Company to opt out.

Patient or authorized person's signature: _____

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Authorization for Treatment

Consent to treatment: I and/or authorized representative voluntarily consent to any and all medical care by Advanced Heart that may include but not limited to examinations, tests, photographs, and treatments by physicians and the staff. No promises have been made to me as to the results of treatments or examinations.

Patient or authorized person's signature: _____

Authorization for Release of Information

Authorization for Release of Confidential Information: I hereby authorize Advanced Heart to release medical information contained in my (the patient's) records to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of records may also be sent to referring physicians and primary care providers for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in our office**.**

Patient or authorized person's signature: _____

Consent for Review of Prescription History

I authorize Advanced Heart to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff.

Patient or authorized person's signature: _____

Notice of Privacy Practice Acknowledgement Form

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been offered a copy of Advanced Heart's Notice of Privacy Practices (available in our office or on our website) and understand that the Notice may change at any time. I give consent to Advanced Heart to obtain my prior medical records from outside practices and send office notes to other physicians to coordinate care on my behalf. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

Patient or authorized person's signature: _____

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Financial Policy

In compliance with the Federal Consumer Protections Act, Advanced Heart is providing you with information regarding your financial responsibilities.

We ask that you take the time to read our policy so we can avoid any misunderstandings. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions.

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care.

Insurance: Advanced Heart participates in many insurance plans. Please contact your insurance company to make sure we participate with your insurance. We do our best in verifying your eligibility and benefits, however, it is your responsibility to know your insurance coverage. It is our policy that you provide us with your insurance card at every visit to our office. If you cannot provide active insurance coverage at the time of services rendered you will be considered uninsured and payment will be due at time of service. It is your responsibility to notify Advanced Heart of any insurance and/or policy changes.

Referral / Authorization: If your insurance company requires a referral/authorization for office visits, testing, or procedures, you are responsible for obtaining the referral/authorization. If the referral/authorization is not obtained, you will be responsible for payment in full for services rendered on the date of service. Some insurance plans require your primary care provider to pre- authorize services done by a specialist. As a courtesy, Advanced Heart will try to obtain the referral/authorization for you.

Patient Payments: Co-pays, deductibles, co-insurance (20%, etc.), services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We accept cash, checks, and most major credit cards. Returned checks will be subject to a fee of $25.00 charged by this office for each check returned to us by your bank. Should you have any balances on your account, we will provide you with a monthly statement. The statement will include but not limited to amounts billed to you, any payments received and detailed aging. It is your responsibility to keep your mailing address current. In cases of hardship, please contact manager or billing representative to see if payment arrangements can be made for outstanding balances. This will be done on case by case bases.

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Collections Policy: Payment for services which have been billed to you is due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule, your account may be turned over to an outside agency for resolution.

No Show Fee: Effective June 16, 2006 there will be a $25.00 fee assessed for no show appointments. No shows are appointments that are not cancelled with a 24 hour notice. With appropriate notice, we are able to schedule other patients in a vacant time slot and to also decrease wait times by not having to work-in emergent patients. Some of our testing and procedures have a separate no show policy.

I assign payment directly to Advanced Heart, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be a delay in payment. I agree to actively pursue collection insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

I understand that I am financially responsible for my (the patient's) account with Advanced Heart, regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

Patient or authorized person's signature: _____

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Initial History and Physical

Please list Primary Care Provider and other healthcare providers involved in your care:_____

_____

Reason for visit:

_____

Medical History- Please list past medical diagnosis (illnesses &Conditions)

Diagnosis	Date	Diagnosis	Date

Previous Surgery- Please list any surgeries

Surgery	Date	Surgery	Date

Do you have an implantable cardiac device? ☐ **YES** ☐ **NO**

☐ Implantable Defibrillator (ICD) ☐ Pacemaker ☐ Loop Recorder ☐ Watchman ☐ CardioMEMS
☐ LVAD ☐ Abott (St Jude) ☐ Medtronic ☐ Biotronik ☐ Boston Scientific

Have you had valvular surgery? ☐ **YES** ☐ **NO**

☐ Aortic Valve	☐ TAVAR	☐ Mechanical	☐ Bioprothetic (tissue)	☐ Repair
☐ Mitral Valve	☐ MitraClip	☐ Mechanical	☐ Bioprothetic (tissue)	☐ Repair
☐ Tricuspid Valve			☐ Bioprothetic (tissue)	☐ Repair
☐ Pulmonary Valve			☐ Bioprothetic (tissue)	☐ Repair

Have you had any previous **coronary stents**? ☐ **YES** ☐ **NO** Date:_____
Have you had any previous **coronary artery bypass**? ☐ **YES** ☐ **NO** Date:_____
Have you had any previous **peripheral (leg) stents**? ☐ **YES** ☐ **NO** Date:_____
Have you been evaluated for **Heart transplant**? ☐ **YES** ☐ **NO** Date:_____
If yes providers Name: _____
Have you been evaluated for **Kidney transplant**? ☐ **YES** ☐ **NO** Date:_____
If yes providers Name: _____

Family History- Please check all that apply Are you adopted? ☐ Yes

Father	☐ Living	☐ Deceased	☐ Cause of Death / age: _____	☐ Cardiac Illnesses: _____
Mother	☐ Living	☐ Deceased	☐ Cause of Death / age: _____	☐ Cardiac Illnesses: _____

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Social History- Please check all that apply

Marital Status ☐ Single ☐ Widower ☐ Divorced

Employment statues ☐ Full Time ☐ Part time ☐ Student ☐ Retired
List your occupation _____

Are you a smoker ☐ YES ☐ NO If yes, how many daily? _____

☐ **Former Smoker** When did you quit? _____

Do you Drink Alcohol? ☐ YES ☐ NO If yes, how much? _____

Do you use illicit drugs? ☐ YES ☐ NO If yes, what drug and how often?

Have you recently been admitted to the hospital for cardiac symptoms? ☐ YES ☐ NO
If yes, when and where? _____

In the last year, have you had any cardiac testing? ☐ YES ☐ NO
If yes, what, when and where? _____
_____

When was your last eye exam? _____ Do you have: ☐ Eyeglasses ☐ Contacts

Medication- Please List any medication allergies or intolerances and reactions: _____
_____
_____

Please List all your current medications (including supplements, vitamins and over the counter):

Medication Name	Dose / Instruction	Medication Name	Dose / Instruction
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

ADVANCED HEART
GROUP OF GLENDALE, INC.

Patient Name: _____
Date: _____

Review of Systems

Please check all that apply

Constitutional:	☐Weight Loss	☐ Weight Gain	☐ Fatigue
Cardiovascular:	☐ Angina, Chest Pain	☐ Abnormal blood pressure	☐ Abnormal heart rate
	☐ Abnormal EKG	☐ Hypertension	☐ Palpitations
	☐ Heart Attack	☐ Edema, Swelling in legs or feet	☐ Arrhythmia
	☐ Heart Murmur	☐ Edema, Swelling in abdominal	☐ Passing out or Black-out Spells
	☐ Congenital Heart defects	☐ Claudication issues	☐ Leg pain ☐ R ☐ L
	☐ Varicose ☐ R ☐ L	☐ Restless legs ☐ R ☐ L	☐ Leg discoloration ☐ R ☐ L
Respiratory:	☐ Cough	☐ Coughing up blood	☐ Shortness of Breath
	☐ COPD	☐ Asthma	☐ Pneumonia
Ear, Nose and Throat (ENT):	☐ Difficulty hearing	☐Ringing in ears	☐ Vertigo
	☐ Bleeding Gums	☐ Sore Throat	☐ Allergies
Gastrointestinal:	☐ Heartburn	☐ Nausea/Vomiting	☐ Blood in Stool
	☐ Change in bowel movement	☐ Constipation	☐ Diarrhea
	☐ Abdominal Pain	☐ Hemorrhoids	☐ Ulcers
Genitourinary:	☐ Pain while Urinating	☐ Burning while Urinating	☐ Difficult Urinating
Hematologic:	☐ Bruising Easily	☐ Anemia	☐ Enlarged Glands
Musculoskeletal:	☐ Arthritis	☐ Decreased Motion	☐ Gout
	☐ Back Pain	☐ Muscle Pain	☐ Neck Pain
	☐ Joint Pain	☐ Joint stiffness	
Skin:	☐ Rash or Sores	☐ Itching/Burning Skin	☐ Psoriasis
Neurological:	☐ Dizziness	☐ Seizures	☐ Weakness
	☐ Numbness	☐ Tremor	☐ Headache
	☐ Spasticity (Spasm)	☐ Memory Loss	☐ Stroke
	☐ Speech impairment	☐ Difficulty with walking	☐ Difficulty with balance
Psychiatric:	☐ Anxiety	☐ Depression	☐ Insomnia

Patient or authorized person's signature: _____

ADVANCED HEART
GROUP OF GLENDALE, INC.

FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

I understand that Advanced Heart Medical Group of Glendale (AHMG), my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to AHMG. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

- **FINANCIAL LIABILITY:** I have been provided a copy of the AHMG financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to AHMG for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

    - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at AHMG and I have not obtained such a referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at AHMG are not medically necessary and/or not covered by my Insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at AHMG, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.

- **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number_____**Patient Signature** _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at AHMG; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.

- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required 24 HOUR notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided the Group Practice Patient Financial Policies. I understand the information listed above which has been fully explained to me.

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**