Arizona Cardiovascular Care

2501 E Southern Ave #16 Tempe, AZ 85282

Ghassan Fraij M.D.

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX: M / F

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_   ZIP: \_\_\_\_\_\_\_\_\_

CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PROVIDER (Family doctor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CROSS STREET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS:  S  M D W

DO YOU HAVE A LIVING WILL YES or NO   POWER OF ATTORNEY YES or NO IF YES WHO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAY WE LEAVE DETAILED VOICEMAILS REGARDING TEST RESULTS AND APPOINTMENTS?  YES or NO

|  |
| --- |
| INSURANCE INFORMATION |

Primary Insurance(name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance(name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide office with original insurance cards and ID.

WHO MAY RECEIVE INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: SPOUSE   CHILD FRIEND

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: SPOUSE CHILD FRIEND

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: SPOUSE CHILD FRIEND

I AUTHORIZED THE LISTED PEOPLES WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION. I MAY REVOKE THIS AT ANYTIME BY GIVING A WRITTEN NOTIFICATION TO CARDIOVASCULAR ASSOCIATES OF ARIZONA.

 Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES TO MEDICATIONS:  Please circle YES   NO REACTIONS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to Latex, iodine (contrast dye) or shellfish:  YES NO

Surgeries:  Please list surgeries or circle:  None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History: Please circle if you have been diagnosed with the following:

Asthma Anemia Arthritis Blood clots DVT or PE

COPD Diabetes Coronary artery disease Chest pain Heart attack

Heart murmur     Hypertension     High cholesterol HIV/AIDS Pacemaker

Rheumatic Fever Stroke Thyroid disease Hepatitis Ulcers

Tuberculosis   Cancer: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:  Please circle   Family history unknown  /  Family is healthy no known issues.

* Cancer Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother Father   Siblings      Grandparents  Child
* Diabetes : Mother  Father   Siblings Grandparents Child
* Heart attack: Mother  Father   Siblings Grandparents Child
* Heart disease: Mother  Father   Siblings Grandparents Child
* Stoke: Mother    Father   Siblings Grandparents Child

Social History: Please circle your answers

Tobacco Use:  Never Smoker  Current Smoker How much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ex: ½ pack per day, 3 cig/day

Former Smoker Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use  None or Yes, If YES list Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illicit drug use:  No or  Yes If YES what types of drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Use:  None or Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise routinely?  No or Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a medication list with you. Please attach and we will make a copy and return your original.

If not, you can request a form to list your medications.

|  |  |  |
| --- | --- | --- |
|  Medication NamePrescriptions and OTC |  Dose |  How often do you take the medication? |
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Arizona Cardiovascular Care, we are committed to treating and using protected health information about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA). This Notice is effective 08/01/2010, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Arizona Cardiovascular Care, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

• Basis for planning your care and treatment,

• Means of communication among the many health professionals who contribute to your care,

• Legal document describing the care you received,

• Means by which you or a third-party payer can verify that services billed were actually provided,

• A tool in educating health professionals,

• A source of data for medical research,

• A source of information for public health officials charged with improving the health of this state and the nation,

• A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Use and disclosure of your health information in certain special circumstances

∙ To public health authorities and health oversight agencies that are authorized by law to collect information.

∙ Lawsuits and similar proceedings in response to a court or administrative order.

∙ When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

∙ If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.

∙ To federal officials for intelligence and national security activities authorized by law.

∙ For Workers Compensation and similar programs.

∙ To remind you of needed appointments in the future by way of phone or email.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Your health record is the physical property of Arizona Cardiovascular Care, the information belongs to you. You have the right to:

• Obtain a paper copy of this notice of information practices upon request,

• Inspect and copy your health record as provided for in 45 CFR 164.524,

• Amend your health record as provided in 45 CFR 164.528,

• Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,

• Request communications of your health information by alternative means or at alternative locations,

• Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and

• Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Arizona Cardiovascular Care is required to:

• Maintain the privacy of your health information,

• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,

• Abide by the terms of this notice,

• Notify you if we are unable to agree to a requested restriction

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you about a revised notice at your office visit.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

To report a problem, you may contact the practice’s Privacy Officer, at (480) 878-4077.  Thank you for choosing, Arizona Cardiovascular Care PLLC for your care. Your confidence in our services is highly appreciated.

**IMPORTANT SUMMARY NOTICE OF THE PRIVACY OF YOUR HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your privacy is important to us. We record information about you so that we may provide you with quality medical care. We are committed to protecting this information. The notice of privacy describes your rights with regards to your health information, as well as how we may use your health information. This is a summary of the more detailed information contained in your notice of privacy.

YOUR RIGHTS INCLUDE:

1. A right to amend your health information
2. A right to request restrictions on what information we use or how we disclose your health information
3. A right to see an accounting of certain disclosures we have made of your health information
4. A right to receive a paper copy of our notice of privacy practices

This right does have special restrictions and you may request and read the full notice at any time. We may use your health information and/or records to:

1. Plan for your care and help your healthcare providers communicate and work together for you
2. Submit claims to your insurance to pay for your care
3. Help healthcare payers or medical insurance companies make sure services were provided
4. Disclose information to certain officials or organizations as required by law

Everyone who is trained or has access to your information is bound by your confidentiality requirements and signs a confidentiality agreement. We encourage you to read the notice and contact us if you need additional information.

I have read and agree to the Notice of Privacy Practices at Arizona Cardiovascular Care All the information I have given is true to the best of my knowledge.

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_