Caring Cardiology
MEDICAL GROUP

Patient Information

Last Name:_____First:_____MI:_____

Date of Birth: _____ SS# _____ Sex: _____ Marital Status: _____

Address: _____City: _____ State: ____ Zip: _____

What is the best way to contact you? Please check all that apply.

☐ Home Phone: _____ ☐ Cell Phone: _____

Would you like to confirm appointments via HIPAA compliant **text message**? ☐ Yes ☐ No

☐ Email address:_____
(I hereby acknowledge that communication by email is not encrypted and may not be secure.)

Occupation: _____ Employer: _____

Preferred Pharmacy: _____ Phone Number: _____

Address: _____ City:_____

Primary emergency contact: _____ Phone Number: _____

Relationship to patient: _____

Secondary emergency contact: _____ Phone Number: _____

Relationship to patient: _____

Race:

☐ American Indian or Alaska Native Asian ☐ Black or African American
☐ Hispanic ☐ Caucasian ☐ Other Pacific Islander ☐ Other Race: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language:

☐ English ☐ Spanish ☐ Farsi ☐ Vietnamese ☐ Other: _____

Notice to Patients

Authorization of Release

I hereby assign all benefits to Caring Cardiology Medical Group for services rendered to me or said patient. I authorize any holder of medical information about me or said patient to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Caring Cardiology Medical Group and I authorize the release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including, but not limited to, co-payments, deductibles and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if my insurance company does not remit payment on my behalf.

Please be advised that there is a $25.00 fee for any returned check

HIPAA notice of Privacy Practices – Acknowledgement of Receipt

I hereby acknowledge that I received a copy of Caring Cardiology Medical Group's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____
Print Patient's Name

_____ _____
Patient or Patient's Legal Representative Signature Date

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Health History Form

Patient Information:

Last Name: _____First: _____Date of Birth: _____

Main Symptom or Problem:

_____

Have you had any of the illnesses below (Please check all that apply):

- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Emphysema/COPD
- ☐ Circulation Disorder
- ☐ Bleeding Disorder
- ☐ Asthma
- ☐ Liver Disease
- ☐ Diabetes Mellitus
- ☐ Heart Attack
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Cancer
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Other: _____

List all past surgeries (including year of surgery):

_____
_____
_____
_____
_____

List current medications (including dose and how often it is taken):

_____
_____
_____
_____
_____

List all allergies to medications (including type of reaction to medication):

_____
_____

Are you allergic to shellfish or X-ray dye or iodine dye: ☐ **Yes** ☐ **No**

List family history of any medical problems:

_____

_____

_____

_____

If you are exercising, please list the type of exercise, frequency, and duration:

_____

Do you smoke? ☐ **Yes** ☐ **No** **If yes, how much per day?** _____
Have you ever smoked? ☐ **Yes** ☐ **No** **If yes, for how many years?** _____
If you stopped smoking, how long ago? _____ **What age did you start?** _____
Do you drink any caffeinated beverages (ex. coffee, tea, energy drinks) ? ☐ **Yes** ☐ **No**
If yes, how often? _____
Do you drink alcohol? ☐ **Yes** ☐ **No** **If yes, how much?** _____

If female, are you still menstruating? ☐ **Yes** ☐ **No**
Are you pregnant? ☐ **Yes** ☐ **No**
If not pregnant, do you use birth control? ☐ **Yes** ☐ **No**

Do you have any of the following symptoms:

Chest Pain	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Swelling / Edema	☐ Yes	☐ No
Palpitations (Heart pounding or racing)	☐ Yes	☐ No
Dizziness / Lightheadedness	☐ Yes	☐ No
Passing out / Loss of consciousness / Fainting	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Sweats	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Blood Tinged Sputum	☐ Yes	☐ No
Unexplained Weight Gain or Loss	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No
Bloody or black stools	☐ Yes	☐ No
Jaundice or hepatitis	☐ Yes	☐ No
Easy bruising or bleeding	☐ Yes	☐ No

_____ _____ _____
Print Patient's Name Patient's Signature Date

_____ _____
Signature of Legal Representative Relationship to Patient

_____ _____
Doctor's Signature Date

Patient Financial Policy

It is our policy to collect all co-payments, deductibles, and co-insurances at the time of service. Additionally, we may send you a statement if your insurance company determines further patient responsibility. We feel it is important to note that **your insurance coverage is a contract between you and your insurance company, not our office.** We cannot take responsibility for large out of pocket costs, special claim forms, or delays and denials by your insurance company. Please contact your insurance company directly to determine your benefits.

Medicare Insured Patients: We are participating providers of the Medicare program and select Medicare HMO plans. Prior to your appointment, please ensure we are participating providers with your Medicare HMO plan or you will be responsible for the full amount of service charges. Patients are responsible for paying their annual deductible and paying for the 20% co-insurance. We file with secondary/ supplemental carriers when applicable. However, in the event that the secondary does not pay us but determines this is patient responsibility, patients will be billed for that balance.

By signing below I am requesting that payment of authorized Medicare and Medi-Gap/ Medicare Supplemental Insurance benefits be made to or on my behalf to Caring Cardiology Medical Group for any services provided to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for relatable services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. This assignment is in effect until evoked by me in writing. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

Commercially Insured Patients: Please check with your insurance company to see if our doctors are providers for your plan. If our doctors are not providers for your plan, you may still have out-of-network benefits. However, your out-of-pocket costs will most likely be higher. Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the entire unpaid balance left from their insurance regardless of the benefits and payments policies of their carrier. You will be responsible for paying your annual deductible, copayment, co-insurance, and charges for any non-covered services.

By signing this policy, you acknowledge that you have read and understand this agreement and are accepting primary financial responsibility for services rendered. We will send you a bill for the amount your insurance company determines you owe. Our office utilizes collection agencies to further collect on unpaid balances over 120 days past due.

_____	_____	_____
Print Patient's Name	Patient/ Patient's Legal Representative Signature	Date

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Cancellation Policy

Our policy is created to allow for effective scheduling and to ensure all patients wishing to receive services may be accommodated. As a courtesy to both the office and patients on our waiting list, please notify at least 24 hours (one business day) in advance if you are unable to make an appointment.

A cancellation fee of $100.00 may be billed to any patient who miss their appointment or do not notify the office of a cancellation 24 hours (one business day) in advance. Monday appointments must be cancelled or rescheduled by 5pm on Thursday.

This charge is not covered by your insurance.

Additionally, patients who arrive 15 minutes or later to their appointment time may be asked to reschedule and a late fee of $50.00 may be billed. This is to allow us to honor the appointment times of the following patients.

This charge is not covered by your insurance.

By signing below, I acknowledge that I have read these policies and agree to its terms.

_____
Print Patient's Name

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Representative Relationship to Patient

Caring Cardiology
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Patient Name: _____

Date: _____

How Did You Hear About Caring Cardiology?

(Please indicate all that apply.)

- ☐ Referring Physician: _____
- ☐ Hospital (name): _____
- ☐ Internet: _____
- ☐ Family/Friend: _____
- ☐ Other- Please Specify: _____

Patient Partnership Plan

Dear Patient,
Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____
Print Patient's Name Date

_____ _____
Patient Signature Physician Signature