ARIZONA HEART & VASCULAR CLINIC

PATIENT INFORMATION

PATIENT LAST NAME | FIRST | MI | SEX | BIRTHDAY | AGE | MARITAL STATUS

MAILING ADDRESS | CITY | STATE | ZIP | PHONE

PATIENT'S EMPLOYER | OCCUPATION | SOCIAL SECURITY NUMBER

EMAIL ADDRESSS | PREFERRED LANGUAGE

RESPONSIBLE PARTY

RESPONSIBLE PARTY | DOB | RELATIONSHIP | SPOUSE NAME IF DIFFERENT

ADDRESS | CITY | STATE | ZIP | PHONE

EMPLOYER NAME | OCCUPATION

IN CASE OF EMERGENCY NOTIFY

NAME OF NEAREST RELATIVE NOT LIVING WITH PATIENT | RELATION

ADDRESSS | CITY | STATE | ZIP | PHONE

INSURANCE INFORMATION

PATIENT ***PRIMARY*** INSURANCE | GROUP NAME **OR** GROUP NUMBER | POLICY NUMBER

INSURANCE CLAIM ADDRESS | CITY | STATE | ZIP | PHONE

POLICY HOLDERS NAME | POLICY HOLDERS SS# | DATE OF BIRTH

PATIENT ***SECONDARY*** INSURANCE | GROUP NAME **OR** GROUP NUMBER | POLICY NUMBER

INSURANCE CLAIM ADDRESS | CITY | STATE | ZIP | PHONE

POLICY HOLDERS NAME | POLICY HOLDERS SS# | DATE OF BIRTH

REFERRED BY

ARIZONA HEART & VASCULAR CLINIC

6316 w, Union Hills Drive, Suite 210, Glendale, AZ 85308
Phone: 480-765-2800 **Fax:** 480-765-2799
www.azheartandvascular.com

Today's Date: **HEALTH & HISTORY**

PATIENT INFORMATION

Patient's last name: First: Middle: ☐Mr. ☐Mrs. ☐Miss ☐ Ms.

Marital status: ☐Single ☐Mar ☐Diiv ☐Sep ☐Wid

Age: Sex: ☐M ☐F Height: Weight:

Race:
☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐White
☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐Other

Primary Care Physician: Phone Number: May we send a report? ☐Yes ☐No Pharmacy: Phone Number

On Coumadin (Warfarin/Blood Thinners)?
☐No ☐Yes **Followed by?**

Pacemaker?
☐No ☐Yes Brand: _____

Referring Provider?

PERSONAL HISTORY

☐AIDS/HIV
☐Asthma
☐CAD
☐CABG
☐Cancer _____
☐Carotid Disease
☐Congestive Heart Failure
☐COPD
☐Diabetes
☐DVT
☐Gout
☐Heart Attack – If yes, when? _____
☐Heart Murmur
☐Hiatal Hernia/Reflux
☐High Blood Pressure
– If yes, how is it treated? _____
☐High Cholesterol or Triglycerides
– If yes, how is it treated? _____
☐Kidney/Urinary Problems
☐Mitral Valve Prolapse
☐Palpitations/Irregular Heart Beats
☐Peripheral Vascular Disease
☐Pulmonary Embolism
☐Pulmonary Hypertension
☐Rheumatic Fever
☐Seizures
☐Sleep Apnea
☐Stroke – If yes, when? _____
☐Thyroid Disorder
☐Ulcers
☐Valvular Heart Disease
☐Varicose Veins
☐Other:

_____

_____

_____

Do you experience any of the following?
☐Bruise or Bleed Easily ☐Cough ☐Chest Pain/Pressure/Discomfort
☐Dizziness ☐Edema (Swollen legs/ankle/feet ☐Fatigue
☐Heartburn ☐Palpitations/Irregular Heart Beats ☐Sleep Disorder
☐Leg Pain when walking ☐Nausea/vomiting/Abdominal Discomfort
☐Shortness of Breath while resting ☐Shortness of Breath on exertion

Have you had any of the following procedures?
If so, when and where?
☐Angioplasty/Stent _____
☐Heart/Blood Vessel Surgery _____
☐Heart Catheterization _____
☐Heart Valve Replacement _____
☐Pacemaker/ICD _____
☐Treadmill Exercise/Nuclear Stress Test _____
☐Echocardiogram _____

SOCIAL HISTORY

☐Smoking
If yes, how many per day? _____
If you quit, when? _____

☐Alcoholic Beverages
If yes, how much per day? _____

☐Caffeinated Beverages
If yes, how many per day? _____

☐Exercise
If yes, how often and what type? _____

Do you have any children? ☐NO ☐YES, Number of Children _____

Do you have an Advanced Directive? ☐NO ☐DNR ☐Living Will ☐Power of Attorney

WOMEN ONLY

Are you on Birth Control? ☐NO ☐YES
Are you pregnant? ☐NO ☐YES
Planning to become pregnant? ☐NO ☐YES
Post-Menopausal? ☐NO ☐YES
Hysterectomy?
If yes, when? _____

MEN ONLY

Prostate Problems? ☐NO ☐YES

Patient Signature _____

FAMILY HISTORY

Check the box if you have a *FAMILY HISTORY* of the following:

☐Heart Attack relationship _____ ☐Stroke relationship _____ ☐Diabetes relationship _____

☐High Blood Pressure relationship _____ ☐High Cholesterol relationship _____ ☐Sudden Cardiac Death relationship _____

☐PVD, Abdominal Aneurysm relationship _____ ☐Other_____ relationship _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? *Please Include Prescription and Over the Counter*

Medication	Dose	Times per Day	Medication	Dose	Times per Day

What Medications are you allergic to?

MEDICATION	REACTION	MEDICATION	REACTION

PLEASE LIST *ALL* PAST SURGERIES

SURGERY	DATE	SURGERY	DATE

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.

_____ _____

Patient Signature *Date*

FINANCIAL POLICY & PATIENT RESPONSIBILTY NOTICE

For those insurances we do not participate with, we will file on your behalf directly to the insurance carrier for payment: Insurance co-payments, co-insurance, deductibles and non-covered services are expected to be paid at the time of service. Our office accepts cash, checks, American Express, Visa, MasterCard, Disocver and Care Credit.

INSURANCE: We participate in multiple insurance plans, including Medicare. However, there are several commercial insurance plans that we do not participate with. If you are insured with a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance compnay with any questions you may have regarding your coverage. It is advised that you call and confirm with your insurance carrier that we are contracted with your insurance plan.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All copayments, co insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. When we do not collect copayments, coinsurance and deductibles from patients at the time of service, it can be considered fraud. Please help us in upholding the law by paying your contracted fees at each visit.

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing a provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

CLAIMS SUBMISSION: We will submit your claims for the insurance companies that we are contracted with and assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company.

NONPAYMENT: If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail.

Additional Practice Related Fees and Policies

$50.00 Fee – "No Shows" (failure to provide cancellation notice prior to your scheduled appointment). All appointments must be cancelled 24 hours before the scheduled appointment.

$50.00 Fee – Request to complete Life, Disability, FMLA and many other various types of independent health forms.

$30.00 Fee – For returned checks for non-sufficient funds, which is charged back processing fee to the patient. We will be unable to accept any personal cheks until account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as a method of payment.

Biopsy, Pathology and Lab Samples sent outside of our office are billed independently of Healthfinity, PLLC. You may receive a bill from the outside lab and will be responsible for payment to that facility.

ASSIGNMENT AND RELEASE: By signing below, I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

By signing below, I acknowledge and understand the Financial Policy of Healthfinity, PLLC (d/b/a Arizona Heart and Vascular Clinic) and accept all payment terms under this Policy as well as my responsibility as a patient to know and understand my health insurance benefits for services provided.

PATIENT SIGNATURE DATE

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and also how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Healthfinity, PLLC (d/b/a Arizona Heart and Vascular Clinic) is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES:

The following circumstances may require us to use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collection information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a 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 help prevent the threat.
- If you are a member of U.S. or foreign military forces (including veterans) and if required by the custody of a law enforcement official.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For worker's compensation and similar programs.

YOUR RIGHT REGARDING YOUR HEALTH INFORMATION:

- Communication. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate all reasonable requests.
- You can request a restriction in our use or disclosure of your health insurance information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your case such as family members. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO: Healthfinity, PLLC, 6316 W. Union Hills Drive, Suite 210, Glendale, AZ 85308. A reason for the request must be provided that supports your request for the amendment. Your records will be reviewed, and a determination made within 60 days.
- Right to a copy of Policy. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice contact our receptionist.
- Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: (480) 765-2800. All complaints must be submitted in writing. You will not be penalized for filling a complaint.
- Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of HIPAA Notice of Privacy Practices for Healthfinity, PLLC.

Print Name	Signature (patient or legal guardian)	Date

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally-assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
   Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

healthcurrent

ARIZONA HEART & VASCULAR CLINIC

Opt Out Form

Please complete and return this form to your healthcare provider who will return this form to Health Current.

This is the "Opt Out Form" described in the Notice of Health Information Practices your healthcare provider gave to you. If you opt out, your healthcare providers WILL NOT be able to access your health information through the HIE, even in an emergency. If you are filling out this form for another person, the references to "you," "I" and "my" in this form refer to that other person.

If you do **not** want your health information shared through Health Current, fill in your name, date of birth and choose either Option 1 or 2. Sign the form and give it to your healthcare provider.

Patient Name:_____ **Date of Birth:** _____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

☐ **Option 1 – Block All Health Information**: I do not want any of my health information shared through Health Current.

☐ **Option 2 – Block Some Health Information**: I do not want health information that comes from the healthcare provider listed below shared through Health Current. I understand that if this healthcare provider works for an organization (like a hospital or a medical group), all of my information from that hospital or medical group may be blocked.

If you select Option 2, provide the full name, address and phone number of the healthcare provider you wish to block from sharing your health information through the HIE. Health Current. If you want to block more than one healthcare provider, complete and return this form for each healthcare provider.

Healthcare Provider (First and Last Name)	**Address**	**Phone Number**

Signature of Patient or Patient's Parent/Guardian/Healthcare Decision Maker:_____
Print Name:_____ **Date:**_____
If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

If you are signing on behalf of more than one patient (such as your children), you must fill out a separate form for each patient.

Provider Office Only: *Please complete before sending via secure fax or secure email to Health Current.*

Print Name:_____ Date:_____

Signature:_____