

NAME: _____

Family History:

Did any of your close relatives have a:

Heart Attack?
Or Angina _____ _____ _____ _____ _____ _____
Relation age outcome Relation age outcome

Stroke? _____ _____ _____ _____ _____ _____
Relation age outcome Relation age outcome

Stent/
Angioplasty? _____ _____ _____ _____ _____ _____
Relation age outcome Relation age outcome

Heart Surgery? _____ _____ _____ _____ _____ _____
Relation age outcome Relation age outcome

Review of Other Systems

Check off any problems or symptoms you currently experience:

- Constitutional:** Weight gain/loss ___ Fever or night sweats ___
- Ears, Nose, Mouth, Throat:** Nose bleeds ___ Gum bleeding/swelling ___
Wear dentures ___
- Pulmonary:** Asthma ___ COPD/emphysema ___
- Gastrointestinal:** Ulcer ___ Rectal Bleeding ___ Reflux ___
Gallbladder problem ___
- Musculoskeletal:** Joint pain ___ Weakness ___
- Neurological:** Stroke ___ TIA ___
- Psychiatric:** Diagnosed w/depression ___ Anxiety Disorder ___
- Endocrine:** Thyroid problem ___ Diabetes ___ If so, how many years?
Women: Have you passed menopause? ___ Age ___
- Hematological/Lymphatic:** Bruise easily ___ Blood clots ___

FINANCIAL POLICY STATEMENT

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Associates in Cardiovascular Disease will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Associates in Cardiovascular Disease participates with most insurance carriers, ***it is your responsibility*** at the time of service to verify with your insurance carrier if the particular physician or the service/test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, AICD accepts cash, checks, debit cards, MasterCard or Visa for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible or co-payment(s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service and must sign a waiver.

Although Associates in Cardiovascular Disease may on occasion, as a courtesy to you, file private insurance claims, we will not become involved in disputes between, you and your insurance carrier regarding covered charges, secondary insurance issues or “usual and customary” charges other than supply factual information as requested by the insurance carrier.

THANK YOU FOR TAKING THE TIME TO REVIEW THE ASSOCIATES IN CARDIOVASCULAR DISEASE FINANCIAL POLICY STATEMENT. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS, COMMENTS OR SPECIAL CONCERNS!

Responsible Party Signature: _____ Date: _____

PRINT NAME: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Associates in Cardiovascular Disease's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Associates in Cardiovascular Disease, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Print Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

- Check here if you do not wish voice messages to be left on your answering machine or voicemail.

Daytime phone number: _____

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Cardiovascular Disease (AICD) may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by AICD for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to AICD.

Print Name: _____ Relationship: _____ Date of Birth: _____

Print Name: _____ Relationship: _____ Date of Birth: _____

Print Name: _____ Relationship: _____ Date of Birth: _____

Signature of Patient/Parent/Guardian

Date