# CAPITAL HEART ASSOCIATES

Patient Information**: PLEASE FILL OUT COMPLETELY**

## DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

SSN: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

How did you hear about us? Referring Doctor Yellow Pages Internet Search Word of Mouth Other: _____

Home Address: _____City: _____County:_____ State: ____ Zip: _____

Preferred Mailing Address: _____City: _____ County:_____ State: ____ Zip: _____

**(WE CANNOT ACCEPT A P.O. BOX FOR HOME ADDRESS)**

Sex: Male Female Referring Physician:_____

Employer: _____

Person to Contact in an Emergency: _____

Relationship to Patient: Phone Number:

Preferred Language: _____ Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Decline to Answer

Race: American Indian/Alaskan Native, Asian, Black or African American, Native Hawaiian, Other Pacific Islander, White/Caucasion, Undefined

Preferred Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____City: _____ State: ____ Zip: _____

## INSURANCE

Primary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Policy Holder's SSN: _____ Insurance Co's Phone: _____

Member #: _____Group#: _____

Secondary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Policy Holder's SSN: _____ Insurance Co's Phone: _____

Member #: _____ Group#: _____

Tertiary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Policy Holder's SSN: _____ Insurance Co's Phone: _____

Member #: _____ Group#: _____

I request Capital Heart to file my insurance and authorize payment to be made directly to Capital Heart Associates for services rendered. I authorize medical information to be released to the insurance carrier and/or to any requesting physician. I authorize Capital Heart and its assistants to administer medical treatment.

Signature: _____Date: _____

CAPITAL HEART ASSOCIATES

# Capital Heart Associates, P.A.

## Financial and Insurance Policy

Thank you for choosing us as your provider of cardiology care. Our physicians and staff look forward to serving you. This financial policy explains your responsibility for insurance and payment services.

We will do our best to accurately verify and file your insurance for services rendered; however, benefits quoted by your insurance carrier are not a guarantee of payment. All current insurance information must be provided at the time of service. You are responsible for any and all co-pay, co-insurance, deductible, and non-covered services on the day of service. Full payment is required if we are not contracted with your insurance plan or if you are not covered by health insurance. We accept cash, check, money orders, and most major credit cards as payment for your bill.

We will be happy to initiate any referrals and/or authorizations needed and file any claims directly to your insurance carrier, but we are unable to assume responsibility for any unauthorized treatment. We will attempt to obtain referrals and/or authorizations for your service, but you are ultimately responsible for confirming any referrals and/or authorizations needed for service have been obtained.

We will make every effort to work with you to resolve any outstanding balance. Statements are sent to the address on file for patients with any unpaid balances. Any amounts remaining after the initial billing cycle may be reported to a collection agency and will incur a fee equal to the cost of collection.

Please let a staff member know if you have any questions.

With my signature below, I confirm that I have been informed of and understand the above outlined policies. I authorize Capital Heart Associates to act as my agent in filing my health insurance for payment and I authorize payment of these benefits directly to Capital Heart Associates on my behalf for any services furnished. I authorize any holder of my medical information to release information needed to determine benefits payable for related services. If my insurance does not cover any portion of this visit, I further acknowledge that I am responsible for payment of these services or materials. Unless revoked by me in writing, this authorization is effective indefinitely.

| **Patient/Legal Guardian Signature** | **Relationship to Patient** | **Date** |
|---|---|---|
| | | |

CAPITAL HEART ASSOCIATES

CAPITAL HEART ASSOCIATES, P.A.

COMPLIANCE PROGRAM

**Patient Consent Form**

By signing this form, you are granting consent to Capital Heart to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site (www.capitalheart.com/patientinfo) or contacting our organization at 919-881-0160.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

By signing this form, you are also acknowledging a copy of Capital Heart's Notice of Health Information Privacy Practices has been made available to you.

Signature: _____

Date: _____

CAPITAL HEART ASSOCIATES

**CAPITAL HEART ASSOCIATES, P.A.**

**Authorization for Release of Information**

Name _____ DOB_____

Capital Heart is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| | | |
|---|---|---|
| Leave a message on my answering machine/voice mail: | Yes ☐ | No ☐ |
| Leave a message to remind me of future appointments: | Yes ☐ | No ☐ |
| Speak with a family member in my home about my care: | Yes ☐ | No ☐ |
| Please list authorized family members: | | |
| Speak with a family member calling the office concerning my care: | Yes ☐ | No ☐ |
| Please list authorized family members: | | |
| Speak to family members concerning financial matters: | Yes ☐ | No ☐ |
| Please list authorized family members: | | |

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

| **Patient/Legal Guardian Signature** | **Relationship to Patient** | **Date** |
|---|---|---|
| | | |

CAPITAL HEART ASSOCIATES

Medical History Questionnaire

Name: _____ Age: _____ Sex: ____ Race: _____

Problem to be evaluated: _____

Referring Physician: _____

**Personal Information**

Date of Birth: ___/___/_____ Birthplace: _____ Marital Status: _____

Occupation: _____ Status: Employed [ ] Retired [ ] Disabled [ ]

If disabled, for what reason? _____

**Past Medical History**

Hospitalizations and surgical procedures (continue on back if necessary)

| | Hospital & City | Reason | Doctor | Year |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Childhood and Adult Diseases: (check any you have had)

Asthma [ ] Pneumonia [ ] Tuberculosis [ ] Diphtheria [ ] Syphilis [ ] Kidney Failure [ ]
Bronchitis [ ] Emphysema [ ] Hepatitis [ ] Diabetes [ ] Hypertension [ ] High Cholesterol [ ]

Drug Allergies: _____

**Lifestyle**

Describe Appetite: _____ Recent weight loss/gain? _____

Amount Per Day: Coffee _____ Tea _____ Soft Drinks _____ Alcohol _____

Smoker: Yes/No If yes, how often: _____ How many years? _____

If no, did you ever? Yes/No How often: _____ How many years? ____
When did you quit? _____

Do you have a history of illicit drug use/abuse? Yes/No What drug(s)? _____
How many years? _____ When did you quit? _____

**Patient Signature: _____ Date: _____ MRN: _____**

CAPITAL HEART ASSOCIATES

**Family History**

| Parents | Living? | Age | Health Problems | If deceased, age & cause of death |
|---|---|---|---|---|
| Father | **Yes/No** | | | |
| Mother | **Yes/No** | | | |
| **Siblings** | | | | |
| Male/Female | **Yes/No** | | | |
| Male/Female | **Yes/No** | | | |
| Male/Female | **Yes/No** | | | |
| **Children** | | | | |
| Male/Female | **Yes/No** | | | |
| Male/Female | **Yes/No** | | | |
| Male/Female | **Yes/No** | | | |

| Constitutional | Yes | No | Breast | Yes | No | Musculoskeletal | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Fever | | | Breast Lump | | | Back Pain | | |
| Frequent Infections | | | Breast Pain | | | Difficulty Walking | | |
| Night Sweats | | | Nipple Discharge | | | Joint Aches/Stiffness | | |
| Weakness | | | **Cardiology** | | | Painful Legs/Feet | | |
| Weight Changes | | | **A**bnormal Blood Pressure | | | **Neuro** | | |
| **Skin** | | | Ankle Swelling | | | Convulsions | | |
| Changes in Moles | | | Chest Pain | | | Dizziness | | |
| Dryness and/or Itchy | | | Heart Murmur | | | Fainting | | |
| Skin Color Changes | | | Irregular Heart Beat | | | Headaches | | |
| **HEENT** | | | Leg Pain and/or Swelling | | | Seizures | | |
| Cataracts | | | Rapid Heart Rate | | | Numbness in hands/feet | | |
| Dental Problems | | | **GI** | | | **Psychosocial** | | |
| Glaucoma | | | Abdominal Pain | | | Depression | | |
| Hearing Loss | | | Constipation | | | Fatigue | | |
| Hoarseness | | | Diarrhea | | | Trouble Sleeping | | |
| Nose Bleeds | | | Heartburn | | | **Endocrine** | | |
| Throat/Face Swelling | | | Indigestion | | | Blood Sugar Problems | | |
| Visual Loss | | | Nausea | | | Excessive Sweating | | |
| **Neck** | | | Vomiting | | | Thyroid Problems | | |
| Swollen Glands | | | **GU** | | | **Hematology** | | |
| **Respiratory** | | | Difficulty Urinating | | | Anemia | | |
| Asthma | | | Incontinence (leaking) | | | Easy Bruising | | |
| Bronchitis | | | Painful Urination | | | Abnormal Bleeding | | |
| Coughing Blood | | | Postmenopausal (Female) | | | Blood Clots | | |
| Shortness of Breath | | | | | | | | |
| | | | | | | | | |
| **Reviewed by: (MD)** | **Date:** | | **Reviewed by: (MD)** | **Date:** | | **Reviewed by: (MD)** | **Date:** | |

Do you have a living will? Yes/No If yes, have you provided us with a notarized copy? Yes/No

**For Office Use Only: Copy of Living Will Requested?** _____

**Patient Signature:** _____ **Date:** _____ **MRN:** _____