Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Patient Information

Name: _____ Date of Birth: _____

Social Security Number: _____ ____Male ____Female

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ____ Single ____Married____Separated____Divorced____Widowed

Employer: _____ Occupation: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact

Name: _____ Phone #: _____

Relationship: _____

*****Authorization/Release of Health Information*****

- I hereby authorize AZCVC to release or obtain any medical information needed regarding my examination and/or treatment to my PCP/referring physician.
- I hereby authorize any physician, hospital, or medical care facility to provide all medical history and treatment needed for the continuation of my care to AZCVC.
- I hereby authorize photocopies of this form and my signature to be as valid as the original.

Signature: _____ Date: _____

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Primary Insurance

Insurance Company: _____

Claims Address: _____

Member ID#: _____ Group#: _____

Subscriber Name: _____ Social Security #: _____

Subscriber DOB: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Claims Address: _____

Member ID#: _____ Group#: _____

Subscriber Name: _____ Social Security #: _____

Subscriber DOB: _____ Relationship to Patient: _____

Tertiary Insurance

Insurance Company: _____

Claims Address: _____

Member ID#: _____ Group#: _____

Subscriber Name: _____ Social Security #: _____

Subscriber DOB: _____ Relationship to Patient: _____

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Medication List

Name:	Dosage:	Tablets a day:	Notes:

(List additional medications on back of this form)

******Allergies****** Please list any known allergies or reactions to medications******

_____

Medical History

Congestive Heart Failure	Yes	No	When? _____
Heart Attack (Myocardial Infarction)	Yes	No	When? _____
High Blood Pressure	Yes	No	When? _____
Diabetes	Yes	No	When? _____
Stroke	Yes	No	When? _____
High Cholesterol	Yes	No	When? _____
Thyroid Problem	Yes	No	When? _____
Cancer	Yes	No	When? _____
Lung Disease	Yes	No	When? _____
Kidney Problem	Yes	No	When? _____

Other: _____

Cardiac Testing/Labs

EKG	Yes	No	When? _____
Stress Test	Yes	No	When? _____
Echocardiogram	Yes	No	When? _____
Ultrasound	Yes	No	When? _____
Labs	Yes	No	When? _____

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Surgical History (Please list all prior surgeries/operations with dates)

1. _____
2. _____
3. _____
4. _____
5. _____

Family History (Please list the status of your immediate family members)

Mother	Alive	Deceased	Age/Cause of Death: _____
Father	Alive	Deceased	Age/Cause of Death: _____
Brother(s)	Alive	Deceased	Age/Cause of Death: _____
Sister(s)	Alive	Deceased	Age/Cause of Death: _____
Daughter(s)	Alive	Deceased	Age/Cause of Death: _____
Son(s)	Alive	Deceased	Age/Cause of Death: _____

Social History

Do you smoke?
( ) Never
( ) Current (____packs/day for _____years)
( ) Quit (Date: _____)

Type of Tobacco used:
( ) Cigarettes ( ) Pipes ( ) Snuff ( ) Chew

Are you interested in quitting? ( ) Yes ( ) No
Do you use recreational drugs? ( ) Yes ( ) No
Do you drink alcohol? ( ) Yes (_____drinks a day) ( ) No
Do you drink Caffeine? ( ) None ( ) Soda (_____/day) ( ) Coffee/Tea (_____/day)
Do you exercise regularly? ( ) Yes ( ) No

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Privacy Policy

HIPPA is the Health Insurance Portability and Accountability Act (HIPPA). It was put into place to protect patient privacy and to ensures privacy of all accumulated health information that belongs to the patient. It was signed into law in 1996 under the United States Department and Human Services. Healthcare providers nationwide were required to comply with rules and regulations of privacy protection by April of 2003. Your private health information is protected by federal law. You have rights regarding your personal information and it provides specific rules and regulations on who may have access to it.

The HIPPA agreement stated that you must be given the "Notice of Privacy Practices" statement which belongs to the facility that you have an appointment with. The notice stated how the healthcare providers use the information from your personal medical file and when and who they can give the information to. If you are a regular patient at a facility, you may only have to sign the HIPPA paperwork once and then it will become part of your file. Some facilities do require you to sign one at every visit however, it depends on the policy of the facility.

Medical staff sign an agreement at least once a year, stating that they are aware of the provisions of the law, that they understand these laws and they will uphold these laws. These are kept on file at the facility at which they work. States may differ in their requirements, but the basic privacy laws must be upheld.

You can ask to see your records and to get copies of them at any time. You can have any corrections that you feel need to be made, included in your chart.

It protects any kind of health information such as office visits, tests, procedures, and diagnosis or other facets of medical care. Information that is spoken, printed or transmitted electronically all falls under the HIPPA privacy act.
Your healthcare provider does have the right to share your information with:

- Other healthcare professionals involved in your care
- For coordination of your healthcare with other specialist/specialties
- With any family, friend or other people that YOU determine as acceptable, to help with your medical care and/or finances and billing

Anyone directly involved in your care would have access to your information; doctors, nurses, other medical personnel, billing offices, any specialist, personnel whom perform lab tests, diagnostic tests and/or procedures either inpatient/outpatient may also have access to your records for the time that you are in their care.

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Privacy Notice

Acknowledgment of Receipt of Privacy Policy (original to be kept in patient's medical records)

By signing below, I acknowledge that I have read the office Privacy Policy Statement and I may request a copy for my records.

Signature: _____ Date: _____

Release of Information

Note: This release of information form supersedes any other release of information form on file in this office and is effective until revoked by me in writing.

Patient Name: _____ DOB: _____

May we leave a message on your answering machine regarding your test or exam results, appointments, billing information or medication refills? ( ) Yes ( ) No

May we mail or fax you copies of any labs, x-rays, other test results and/or medical records with a verbal consent request from you? ( ) Yes ( ) No

Please list below who our office can talk to regarding your medical treatment and/or billing information?

Name: _____ Phone #: _____

Relationship to patient: _____

Name: _____ Phone #: _____

Relationship to patient: _____

(If you would like to authorize more people, please use the back of this form)

Signature: _____ Date: _____

Arizona Cardiovascular Consultants & Vein Clinic
3850 E. Baseline Rd. Bldg. 1 Suite 102
Mesa, Az. 85206
P: 480-924-0006
F: 480-924-0659

Patient Waiver/Financial Responsibility (All patients must sign)

By signing below, I understand that I will be responsible for the cost of all medical services rendered. I hereby authorize payment directly to AZCVC under terms of my insurance. I agree to pay all copayments at the time the services are rendered. I understand that by not providing all insurance cards at the time of my visit, it allows for billing to be submitted to the only carrier I have provided, therefore, all financial responsibilities, after submission of billing to said insurance, will be my responsibility.
(Including Medicare Guidelines)

Signature: _____ Date: _____

Notice to All Patients (All patients must sign)

By signing below, I understand that the time dedicated to my appointments/testing requires advanced planning on the part of AZCVC. **I further understand that if I do not show up for my scheduled appointment and I fail to call and cancel or reschedule the appointment I will be liable for a $50.00 no show fee; as such appointment could have been assigned to another patient.**

Signature: _____ Date: _____