CARDIOVASCULAR INSTITUTE OF NEW ENGLAND

****PATIENT INFORMATION****

Name: _____ Today's Date:_____/_____/_____

Street Address:_____

City: _____ State:_____ Zip Code: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Sex: M or F

Home Phone #: _____ Cell/Work Phone #:_____

EMAIL: _____(Required to Pre-Register for Patient Portal)

****IS IT OK TO LEAVE A MESSAGE ON YOUR:**** _____HOME# _____ CELL# _____ WORK#

Marital Status: _____ Married _____ Single _____Divorced _____Widow

Primary Care Physician:_____ PCP Phone #:_____

Emergency Contact Person:_____ Phone #:_____

Relationship to Patient:_____ *IS IT OK TO SPEAK WITH THIS PERSON REGARDING YOUR MEDICAL INFORMATION?** YES or NO (Please circle one)

Race: _____American Indian or Alaska Native _____Asian _____Black or African American
_____Native Hawaiian or other Pacific Islander _____Other race _____White

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Patient Refused

Preferred Language: _____

Secondary Language: _____

Collecting patient race, ethnicity, and language is part of a process promoting effective communication, cultural competence, and patient and family-centered care. By collecting these types of data, our office can better serve our patients.

The law permits health care organizations to collect race, and ethnicity from patients. Many laws require reporting of race and ethnicity. There is no known law stating that it is illegal to ask patients for information on their race and/or ethnicity. The 1964 Civil Rights Act allows hospitals and health care organizations to collect information on patients' race, ethnicity, and spoken language to improve health care quality.

IOV HEALTH HISTORY FORM

PLEASE FILL OUT FRONT AND BACK OF FORM

PATIENT NAME:_____ **DATE OF BIRTH:**____/____/____

TODAY'S DATE:____/____/____ ***WHAT IS THE REASON FOR TODAY'S VISIT?**_____

MEDICATIONS

Pharmacy Name:_____ **Phone #:**_____

Pharmacy Address:_____ **City:**_____ **State:**_____

PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING INCLUDING STRENGTH AND DOSAGE(S):

_____

_____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS: **YES** or **NO**

If YES, please list the medication(s) and the reaction(s):

_____

_____

_____

HEALTH HISTORY

Name:_____ Date of Birth:_____

1.) PAST MEDICAL HISTORY: Please circle YES or NO if you have ever been diagnosed with any of the following:

High Blood Pressure	Yes	or	No	Thyroid Disease	Yes	or	No
High Cholesterol	Yes	or	No	Cancer	Yes	or	No
Heart Disease	Yes	or	No	Sleep Apnea	Yes	or	No
Diabetes	Yes	or	No	Stroke/TIA	Yes	or	No
Rheumatic Fever	Yes	or	No	COPD	Yes	or	No
Vascular Disease	Yes	or	No	Asthma	Yes	or	No
Blood Disorder	Yes	or	No	Bronchitis	Yes	or	No
Ulcers	Yes	or	No	Anxiety	Yes	or	No
Acid Reflux	Yes	or	No	Depression	Yes	or	No
Atrial Fibrillation	Yes	or	No	Psychiatric Illness	Yes	or	No
Hepatitis	Yes	or	No	History of STD	Yes	or	No

If you answered yes to any of the following, please explain:

_____

_____

_____

2.) FAMILY HISTORY: Please circle YES or NO to the following: If answering yes please list relationship to patient and age of onset if known.

Heart Attack:	Yes	or	No	_____
Angina:	Yes	or	No	_____
CHF: (Congestive Heart Failure)	Yes	or	No	_____
Sudden Cardiac Death	Yes	or	No	_____
High blood pressure:	Yes	or	No	_____
High Cholesterol:	Yes	or	No	_____
Stroke	Yes	or	No	_____
Diabetes	Yes	or	No	_____

3.) WORK HISTORY: Please circle YES or NO.

What kind of work and for how long? _____

4.) SOCIAL HISTORY: Please circle YES or NO.

Do you smoke cigarettes?	YES	or	NO	If yes, how much_____
Have you ever smoked?	YES	or	NO	If yes, when did you quit _____
Do you drink alcohol?	YES	or	NO	If yes, how much per day/week_____
Do you use recreational drugs?	YES	or	NO	If yes, explain_____
Do you drink caffeine?	YES	or	NO	If yes, how much per day_____

5.) SURGICAL/HOSPITALIZATIONS HISTORY: Please list any prior surgeries/hospitalizations including dates/year.

_____

_____

_____

6.) REVIEW OF SYSTEMS: Please check if you have any of the following:

Constitutional: ( ) Fatigue ( ) Weight Change ( ) Fever

Eyes: ( ) watery ( ) blurry vision ( ) redness

Ears, Nose, Mouth, Throat: ( ) hoarseness ( ) ear pain ( ) throat pain

Allergy: ( ) sneezing ( ) post-nasal drip

Cardiac: ( ) chest pain ( ) palpitations ( ) shortness of breath lying down ( )SOB at night ( ) SOB bending ( ) swollen legs/ankles

Respiratory: ( )wheezing ( ) cough

Gastrointestinal: ( ) heartburn ( ) stomach pains ( ) nausea ( ) vomiting ( ) trouble swallowing

Urinary: ( )burning on urination ( ) urinary infection ( ) urinary frequency ( ) urinating at night

Muscle/Joints: ( ) joint pain ( ) muscle aches

Neurologic: ( ) headache ( ) lightheadedness ( ) dizziness ( ) passing out

Psychiatric: ( ) depression ( ) anxiety

Skin: ( ) rash ( ) itching

Endocrine/Hormones: ( ) heat or cold intolerance

Hematology: ( ) bleeding tendency ( ) easy bruising

CARDIOVASCULR INSTITUTE OF NEW ENGLAND

Rhode Island Cardiovascular Division

Office Policy

PATIENT NAME:_____ **DATE OF BIRTH:**_____

The Doctors and staff of Cardiovascular Institute of New England, Rhode Island Cardiovascular Division, would like to welcome you to our practice. We look forward to providing you quality care and will do our best to make your visit positive and successful.

Our office has State of the Art On-Site Cardiovascular Testing

In order to maintain a high level or service in the current, difficult healthcare market in Rhode Island, please make note of the following billing policies effective 1/1/2015.

RELEASE OF MEDICAL RECORDS- For your protection, we allow for the release of medical records only with your written consent. Simply contact our office and we will be happy to provide you with the necessary forms to initiate your request.

PRESCRIPTION REFILLS - Please allow 48 hours (2 business days) for prescription refills.

MISSED APPOINTMENTS- You share in the responsibility of your medical care and are obligated to keep your scheduled appointments. If you are unable to keep your appointment, we require 24 hours notice. If you miss your scheduled appointment, you will be charged $25.00.
A $50.00 fee will be charged for missed nuclear stress test appointments as we need to buy isotope (nuclear testing pharmacological material) in advance, which cannot be re-used. A follow up appointment will not be made until fees for missed appointments are paid in full.

INSURANCE CARDS- Please be sure to bring your insurance card(s) and a Picture ID with you to your appointment. If your insurance requires a referral, please be sure to bring it with you or have your primary care fax it to us. If you have had blood work or any other testing done, please have your doctor forward copies to us prior to your appointment or bring them with you.

FINANCIAL RESPONSIBILITY- You are responsible for all financial aspects of your medical care. Co-Pays are required at time of visit. A service charge of $10.00 will be applied if payment not made. We accept most major credit cards.

I have read and agree to the above terms.

_____ DATE:_____

Signature:

Rhode Island Cardiovascular Group, Inc.

NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for the future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Rhode Island Cardiovascular Group, Inc. is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the practice's reception area and will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in our reception area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You

The following categories describe examples of the way we use and disclose medical information:

1. For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians, medical students, or other personnel who are involved in your care. For example, a laboratory or medical specialist may need to know information about you to run tests or to provide treatment.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical provider may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

2. Future Communications: We may communicate to you via newsletter, mailings, or other means regarding treatment options; information on health-related benefits or services, disease-management programs, wellness programs; to assess your satisfaction with our services; to remind you that you have an appointment for medical care; as part of fund raising efforts; for population based activities relating to improving health or reducing health care costs; for conducting training programs or reviewing competence of health care professionals; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer [or designated person].

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

1. As required by law, we may use and disclose health information to the following types of entities, including but not limited to:
    a. Food and Drug Administration
    b. Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability.
    c. Correctional Institutions
    d. Workers Compensation Agents
    e. Organ and Tissue Donation Organizations
    f. Military Command Authorities
    g. Health Oversight Agencies
    h. Funeral Directors, Coroners and Medical Directors
    i. National Security and Intelligence Agencies
    j. Protective Services for the President and Others
    k. Authority that receives reports on abuse and neglect

2. Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

3. State-specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

A Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this Notice. To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with your clinician by calling (401) 464-9755, and ask to speak to the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Lisa Brewer
Telephone Number: (401) 464-9751, ask to speak to the Privacy Officer

By signing below, you confirm that you have read and understand the Notice of Patient Privacy Practices.

_____ _____

Patient Signature or Authorized Representative **Date**