Southwest CardioVascular Associates

7529 E. Broadway Rd., Mesa, AZ 85208
Rapid Referral Line: **480-945-4343**
Rapid Referral eFax: **480-522-3030**

▼ 01 - PATIENT INFORMATION ▼

How Did You Find Us? _____

PATIENT NAME: _____ _____ _____
First *Middle* *Last*

PRIMARY *(AZ)* **ADDRESS:** _____ _____ _____ _____
Street Address *City* *State* *Zip*

SECONDARY ADDRESS: _____ _____ _____ _____
Street Address *City* *State* *Zip*

HOME PHONE: _____ **CELL:** _____

***E-MAIL:** _____ **PATIENT PORTAL ACCESS:** Yes No (Circle One)

BIRTH DATE: _____ - _____ - _____ **SOC. SEC.** *(or SIN)* **#:** _____ - _____ - _____
Month *Day* *Year*

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown **GENDER:** ☐ Male ☐ Female

RACE: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Asian ☐ White/Caucasian ☐ Other Race ☐ Unknown
☐ Native Hawaiian/Pacific Islander

MARITAL STATUS: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Other Relationship

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

EMERGENCY CONTACT PHONE: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

PHARMACY: _____

(If Patient, check here ☐ and skip to Insurance Information)

GUARANTOR NAME: _____ _____ _____ **GENDER:** ☐ Male ☐ Female
First *Middle* *Last*

BIRTH DATE: _____ _____ _____ **RELATIONSHIP TO PATIENT:** ☐ Parent ☐ Spouse ☐ Employer ☐ Child ☐ Life Partner ☐ Other _____
Month *Day* *Year*

▼ INSURANCE POLICY INFORMATION ▼

PRIMARY INSURANCE: _____ **EFFECTIVE DATE:** _____

POLICY ID #: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: _____ **EFFECTIVE DATE:** _____

POLICY ID #: _____ **GROUP NUMBER:** _____

▼ INSURANCE AGREEMENT ▼

†By signing my name below, I hereby give permission to treat me and/or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have.

†I authorize the release of any medical information necessary to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

†

_____ _____
PATIENT SIGNATURE **DATE**

02 - PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

Do you currently have or recently have had any of the following symptoms?

CARDIOVASCULAR		
High Blood Pressure	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Chest Discomfort	☐Yes	☐No
Fluttering Feeling in Chest	☐Yes	☐No
Skipped Heartbeats	☐Yes	☐No
Swelling in Ankles/Feet	☐Yes	☐No
Varicose Veins	☐Yes	☐No

CONSTITUTIONAL		
Significant Weight Loss	☐Yes	☐No
Significant Weight Gain	☐Yes	☐No
Night Sweats	☐Yes	☐No
Unexplained Fever	☐Yes	☐No

ENDOCRINE		
Thyroid Problem	☐Yes	☐No

EAR/NOSE/MOUTH/THROAT		
Difficulty Swallowing	☐Yes	☐No
Dry, Hoarse Throat	☐Yes	☐No

EYES		
Blurred/Double Vision	☐Yes	☐No
Cataracts	☐Yes	☐No
Glaucoma	☐Yes	☐No

GASTROINTESTINAL		
Indigestion/Nausea	☐Yes	☐No
Ulcers	☐Yes	☐No
Diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Abdominal Pain	☐Yes	☐No

GENITOURINARY		
Loss of Bladder Control	☐Yes	☐No
Blood in Urine	☐Yes	☐No

HEMATOLOGY/LYMPHATIC		
Breast Masses/Lumps	☐Yes	☐No
Enlarged Lymph Nodes	☐Yes	☐No
Unexplained Bruising	☐Yes	☐No

INTEGUMENTARY		
Skin Rash	☐Yes	☐No

MUSCULOSKELETAL		
Arthritis	☐Yes	☐No
Back Pain	☐Yes	☐No
Muscle Weakness	☐Yes	☐No
Leg Pain	☐Yes	☐No

NEUROLOGICAL		
Headaches/Migraines	☐Yes	☐No
Memory Loss	☐Yes	☐No
Speech Problems	☐Yes	☐No
Dizziness/Fainting Spells	☐Yes	☐No
Stroke	☐Yes	☐No

PSYCHOLOGICAL		
Depression	☐Yes	☐No
Anxiety	☐Yes	☐No
High/Unusual Stress	☐Yes	☐No
Eating Disorder	☐Yes	☐No

RESPIRATORY		
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Chronic Cough	☐Yes	☐No
Wheezing	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
History of Tuberculosis	☐Yes	☐No
Valley Fever	☐Yes	☐No
Lung Disease	☐Yes	☐No

PATIENT NAME _____ DATE _____

03 - PATIENT MEDICAL HISTORY

Please check all medical issues you have now or have had in the past:

Heart Disease	☐Yes	☐No	**Heart Murmur**	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	**Stroke**	☐Yes	☐No
Renal/Kidney Failure	☐Yes	☐No	**Diabetes**	☐Yes	☐No
Lung Disease	☐Yes	☐No	**Anesthesia Problems**	☐Yes	☐No
Intestinal Disease	☐Yes	☐No	**Valley Fever/TB**	☐Yes	☐No
Thyroid Disease	☐Yes	☐No	**Drug Abuse**	☐Yes	☐No
Asthma/Emphysema	☐Yes	☐No	**Cancer**	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	***If Yes, Type of Cancer:***		

SURGICAL PROCEDURES & OPERATIONS

Please list all previous surgical procedures and operations, including dates for each:

SURGICAL PROCEDURE/OPERATIONS	DATE	RECENT HOSPITAL VISITS/IMAGES	DATE

PATIENT FAMILY HISTORY

Has anyone in your immediate, biological family ever had any of the following?
(Grandparents, Parents, Sisters and/or Brothers)

Heart Disease	☐Yes	☐No	**Heart Murmur**	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
High Blood Pressure	☐Yes	☐No	**Stroke**	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
Bleeding Disorders	☐Yes	☐No	**Diabetes**	☐Yes	☐No
If Yes, Who?			***If Yes, Who?***		
Renal/Kidney Failure	☐Yes	☐No	**Valley Fever/TB**	☐Yes	☐No
If Yes, Who?			*If Yes, Who?*		
Lung Disease	☐Yes	☐No	**Cancer**	☐Yes	☐No
If Yes, Who?			*If Yes, Who and Type of Cancer?*		

Please inform our office staff of any Living Will, Advanced Directive or Do Not Resuscitate guidelines that you may have and supply our office with a copy for your records.

PATIENT NAME _____ DATE _____

CURRENT MEDICATION LIST

Date

I, _____, understand that SWCVA physicians rely on medication information I provide to them for my care, and that any medication misinformation can result in hospitalization or death. By signing this, I confirm the medication information I am providing here is accurate and complete.

Patient Signature *Birth Date*

Are you currently enrolled with a Pain Management Service? ☐ YES ☐ NO
If yes, please provide the following contact information:
Practice Name:
Phone: Address:

PATIENT ALLERGIES

Drug or Medication Allergies: ☐YES ☐NO	
Allergic to Mold, Pollen, Dust: ☐YES ☐NO	

PATIENT SMOKING HISTORY

Any Past Tobacco Use? ☐YES ☐NO	**If YES, Type of Tobacco Use:** _____
Do You Smoke Now? ☐YES ☐NO	**If YES, # Cigarettes a Day?** _____
	Quit Smoking on (Date): _____

DEVICE/IMPLANT INFO	**MEDICATION ALLERGIES**	**ALLERGIC REACTION**
Type:		
Serial #:		
Implant Date:		

RX CARD INFORMATION

BIN# **GROUP#** **PCN#** **PHONE#**

CURRENT MEDICATIONS

MEDICATION NAME	AMOUNT/ DOSAGE	# TIMES TAKEN DAILY	ORDERING DOCTOR	START DATE

Southwest
CardioVascular Associates

HIPAA Patient Consent Form

_____ ___/___/___
Patient Name (Print) Today's Date

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, however, if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. Such a revocation, however, will not affect any prior consent disclosures authorized by you. SWCVA provides this form to comply with the HIPAA *Health Insurance Portability and Accountability Act* of 1996.

The following has been acknowledged and understood by the patient and/or responsible party:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- SWCVA has a Notice of Privacy Practices available for patient to review at patient's request.
- SWCVA reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of the patient's health information, however, SWCVA is not obligated to agree to those restrictions.
- The patient may revoke this consent with a signed, written request at any time. All disclosures will cease at the time the revocation is submitted. SWCVA may condition receipt of treatment upon the execution of this consent.

_____ _____ ___/___/___
Responsible Party Name (Print) Responsible Party Signature Today's Date

The patient has given consent to the following disclosure:

May we contact you via: **Phone**: O Yes O No **Email**: O Yes O No **Text**: O Yes O No

May we leave messages on the patient's: **Cell Phone**: O Yes O No **Home Phone**: O Yes O No

May we discuss your health information with someone other than yourself? O Yes O No

*If you answered **Yes** for SWCVA to discuss your health information with someone other than yourself*, please enter the following information for all parties you give consent for SWCVA to speak with:

Name	Relationship to patient	Phone number(s)

_____ _____ ___/___/___
Responsible Party Name (Print) Responsible Party Signature Today's Date

_____ _____ ___/___/___
SWCVA Witness Name / Title (Print) SWCVA Witness Signature Today's Date

The Epworth Sleepiness Scale

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Have you ever been diagnosed with any of the following conditions (select all that apply)?:

- O High Blood Pressure (uncontrolled)
- O Heart Failure
- O Atrial Fibrillation
- O Stroke
- O None of the above

Do you feel easily fatigued or lack stamina? O Yes O No

Have you ever received an overnight sleep study? O Yes O No

If Yes, has a physician ever diagnosed you with Central Sleep Apnea CSA or Obstructive Sleep Apnea OSA?

Type:_____When:_____Therapy Prescribed:_____ Compliant: O Yes O No

Patient Name: _____ DOB:_____ Signature:_____

Phone Number:_____

Southwest
CardioVascular Associates

Authorization to Receive/Release Health Information:

Patient Name: _____ **Date of Birth:** _____
Address: _____
Home Phone: _____ **Cell Phone:** _____

Mark one below:
___I hereby authorize Southwest Cardiovascular Associates to REQUEST medical records FROM:
___I hereby authorize Southwest Cardiovascular Associates to RELEASE medical records TO:

Name: _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____

Records Needed for:

Physician Appt on: _____ **Personal Copy:** _____ **Other:** _____
Date

List Specific Medical Records requested:

_____
_____
_____

I hereby release you, your physicians, and your employees from all liability for fulfilling the authorization request for release of medical information. This consent will remain in place unless revoked by written consent after signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Southwest Cardiovascular Associates in writing to that effect. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall constitute a breach of my rights to confidentiality. I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original. Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

IMPORTANT INFORMATION/NOTICES FOR THE RECIPIENT:

The attached photocopies of medical records are requested from you pursuant to the authorization and request the patient specified above on this consent submitted to Southwest Cardiovascular Associates.

THIS FORM MUST BE COMPLETELY FILLED OUT TO PROCESS. PLEASE ALLOW 7-10 BUSINESS DAYS

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN/POA SIGNATURE: _____ **DATE:** _____

NOTICE OF 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.

Southwest Cardiovascular Associates are dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided.

Federal law outlines specific privacy protections and individual rights, related to the information we maintain, that identifies you as a patient. Protected information includes, demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice, outlining our legal duties and responsibilities, related to the use and disclosure of patient identifiable health information, Privacy Practices and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: we may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children or parents.

2. Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with details of your treatment, sharing our payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.

3. Health Care Operations: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.

4. Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.

5. Treatment Options: We may use your health information to inform you of treatment options or other health related services, which may be of interest to you.

6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of our office, such as after hour's telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

7. Research: We may use your information in conjunction with agents of the Practice who may be required to review your files, just as our employees are so permitted, in order to determine whether you are qualified for a research project. If you are asked to join a research project, you will be asked first to execute an authorization, granting the Practice or a research organization the right to use your protected health information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities, including reporting of certain communicable diseases.
- For workers' compensation or similar programs, as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- To health oversight agencies.
- To your employer, if we provide health care services to you at the request of the employer, whereupon, we shall provide you written notice of release of such information.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation, if you are an organ donor.
- For research purposes, under strict limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes, such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign-in sheet.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time, except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

Your health record is the physical property of practice. The information contained in it belongs to you. Below is a list of your rights regarding individually identifiable health information. All requests related to these items must be made in writing, to our privacy officer, at the address listed below. We will provide you with appropriate forms to exercise these rights. We will notify you, in writing, if your requests cannot be granted.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes, requests to restrict disclosure of our health information to only certain individuals, or entities, involved in your care, such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communication: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy of your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Practice, if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you, one time, free of charge, during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

FINANCIAL POLICY AND PATIENT RESPONSIBILITY

We are committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policies.

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Southwest Cardiovascular Associates of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments directly to SWCVA. Any payments sent directly to the patient, should be forwarded to SWCVA with the Explanation of Benefits, to prevent your account from being subject to collections procedures and legal action. Authorization must be signed at the initial visit, upon any changes in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that SWCVA is a participating provider with your insurance company. All referrals to SWCVA are to be obtained prior to your appointment. This will prevent your appointment from needing to be rescheduled.

PAYMENT POLICY

Insured

All co-pays, deductibles and co-insurance must be paid before services are rendered. If unable to pay your amount due at the time of service, your appointment may be rescheduled.

Non-Insured

SWCVA requires full payment at the time of service, unless prior arrangements have been made with our Billing Office.

Balances Due

Patient balances remaining after insurance payments, must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

Medical Forms

SWCVA requires full payment of $30.00 at the time that your Insurance forms (FMLA, FAA Clearance, Disability, ect.) are dropped off for completion. Completion of forms is not paid by your insurance company.

24 hour Cancellation for Appointments

SWCVA requires a 24 hour advance notice for all appointment cancellations. 24 hour advanced notice is defined as 1 full business day, Monday through Friday. Varying fees will be charged to your account depending on the type of appointment. This charge is not covered by your insurance and is the patient's responsibility.

Non-Sufficient Funds/Returned Checks

SWCVA will pass along to the patient a $40.00 NSF bank charge for all returned checks. This fee will be added to your account and is the patient responsibility. The financial institution may charge additional fees to you directly.

FINANCIAL POLICY ACKNOWLEDGEMENT

(Mandatory for All Patients)

†By signing my name below, I acknowledge that I have read and understand the updated Financial Policy of CardioJost, Inc. (Southwest Cardiovascular Associates) as well as the cover letter attached. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check, MasterCard, Discover or Visa. I agree that if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

(Mandatory for All Patients)

†By signing my name below, I authorize the release of medical information necessary for filing health insurance claims for me by CardioJost, Inc. (dba: Southwest Cardiovascular Associates). I also authorize my insurance carriers to make payments directly to these companies.

PATIENT NAME

†

PATIENT SIGNATURE **DATE**