Phoenician Cardiac Care
Phone: (480) 444-7464 Fax: (480) 912-7922
2075 W Pecos Rd #B1 Chandler, AZ 85224
2226 W Northern Ave D-270 Phoenix, AZ 85021
www.phoeniciancardiaccare.com

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Marital Status: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: code: _____

Home Phone: _____ Work: _____ Cell: _____

Social Security #: _____ Email Address: _____

Employer: _____ Phone#: _____Fax#: _____

Address: _____

Emergency Contact Name: _____ Phone#: _____ Relationship: _____

Ethnicity (Hispanic or Latin): _____ (Not Hispanic or Latin): _____ Race: _____Decline to answer: _____

Do you have an ADVANCED DIRECTIVE? LIVING WILL? Yes _____ No_____

If not, would you like information on Advance Directives? Yes_____ No_____

Are you an ORGAN DONOR? Yes_____ No_____

How did you hear about us? Internet _____ Healow_____ Friend_____ Family_____ Advertisement_____ Other_____

HEALTH INSURANCE Copays are expected at time of service and will not be billed.

Primary Carrier: _____

Policy Holder: _____Group#: _____Policy#: _____

Address: _____Phone#: _____

Secondary Carrier: _____

Policy Holder: _____Group#: _____Policy#: _____

Address: _____Phone#: _____

Pharmacy: _____ Address/Cross Streets: _____

I give Phoenician Cardiac Care authorization to view my prescription history from external sources.

The patient verifies that all information provided is true and correct. The patient has full knowledge that the patient is responsible for all services rendered and that he/she is contractually bound to pay for paid services. This includes all costs of collections and a reasonable attorney's fee, if collections become necessary. Patient waives his/her confidentially rights should collection become necessary Patient authorizes and requests payments under insurance plans be paid directly to the above provider for any services provided. Patient also authorizes the release of any information requested by his/her insurance carrier to process insurance claims.

Signature_____ Date_____

MEDICAL HISTORY

Patient Name (first, middle, last):_____D.O.B_____

Reason for today's visit? _____

Medications			
Name of Medications	Strength per pill	Number of pills taken at one time?	Number of doses each day?

☐ Allergies: _____	☐ No known Allergies

Medical Conditions					
Heart Attack		Irregular Heart Rate		Chronic Pain	
Heart Murmur		Blood Clots		PAD	
Rheumatic Fever		Kidney Failure		CHF	
Angina		Stroke/TIA		Varicose Veins	
High Cholesterol		Hypertension		Lymphedema	
Atrial Fibrillation		Diabetes		Other	

Family History							
	Alive/Age	Deceased	Hypertension	Diabetes	Heart Disease	CVA	Varicose Veins
Father							
Paternal Grandmother							
Paternal Grandfather							
Mother							
Maternal Grandmother							
Maternal Grandfather							
Children							
Children							

Social History

Tobacco Use:

Are you a: □ Current Smoker □ Former Smoker □ Never Smoked

If current Smoker:

How many cigarettes/Cigars do you smoke per day? □ <5 □ >5-10 □ >11-20 □ >21

How long have you smoked? _____

If you have attempted to quit, date of last attempt _____

If you are former smoker:

How long ago did you quit: □ 1-3 months □ 4-8 months □1-5 years □ 5+ years

How many cigarettes per day did you smoke? _____

Alcohol use:

How often do you drink alcohol? □ Never □ Rarely □ Weekly □ Daily

If daily, how many drinks per day? _____

If you quit drinking, when_____

Drug Use: (Marijuana or other type)

If illicit substance use, please specify substance? _____

Frequency of use? _____

If quit, when? _____

Caffeine use:

Do you drink caffeine (check all that apply)? □ Coffee □ Tea □ Soda □ Monster Drink □ None

How many per day? _____

REVIEW OF SYSTEMS (mark all that apply)					
Constitutional		**Cardiovascular**		**Musculoskeletal**	
Headaches		History of heart disease		Muscle pain	
Prior Anesthesia Problems		Swelling in hands, feet or ankles		Ambulatory aide	
Regular exercise		Shortness of breath while walking		Joint pain	
Fatigue		Shortness of breath while lying flat		**Dermatologic**	
Fever		Chest pain		Hair changes	
Loss of appetite		Hypertension		Change of skin color	
Night sweats		Coronary artery disease		Itching or rash	
Weakness		Palpitations		Nail changes	
Weight Change		**Gastrointestinal**		Suspicious legions	
Chest/Breast		Painful bowel movements		Varicose veins	
Lumps		Abdominal pain		**Neurological**	
Tenderness		Blood in stool		Numbness	
Discharge		Change in bowel habits		Dizziness	
HEENT		Constipation		Headaches	
Blurred or change in vision		Diarrhea		Memory Loss	
Eye disease or injury		Nausea		Trouble with balance	
Gum or teeth problems		Vomiting		Coordination issues	
Difficulty swallowing		Rectal bleeding		**Psychiatric**	
Glasses or contacts		Other		Anxiety	
Loss of hearing or ringing in ears		**Hematology**		Confusion	
Frequent nose bleeds		Abnormal clotting		Depression	
Endocrine		Anemia		Insomnia	
Hormone disorder		Easy bleeding		Suspicious Legions	
Diabetes		Easy Bruising		Varicose veins	
If diabetes, insulin use?		Enlarged lymph nodes		**Respiratory**	
Cold intolerance		Past transfusion		Sleep Apnea/Snoring	
Heat intolerance		Slow healing		Cough	
Excessive thirst		**Genitourinary**		Shortness of breath	
Excessive urination		Hard to starting urinating		Trouble breathing	
Thyroid disorder		Blood in urine		Wheezing	
		Burning when urinating			
		Frequent night urinating			
		Kidney disease			

Patient Signature: _____ Date: _____

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Are you at risk for Peripheral Vascular Disease (PVD)?

Your answers to these questions will help you know.

PVD is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrowed or clogged, Please fill out thus questionnaire to see if you have the symptoms of PVD. The more yes answers you checked, the more important it is for you to see a Vascular Specialists.

Check yes or no to the following questions.	Yes	No	Sometimes
1. Do you experience aching, cramping, swelling or pain in your arms legs or buttocks when you walk or exercise?			
2. If you answered yes to question # 1 does the pain subside with rest?			
3. Do you have numbness, tingling or burning in the arms, lower legs and feet? Do your legs feel heavy?			
4. Are your fingers or toes, pale, disorder or bluish?			
5. Are your hands or feet cold to the touch?			
6. Do you have any painful sores or ulcers on legs or feet that don't heal?			
7. Do you now or have you ever smoked cigarettes?			
8. Do you have diabetes?			
9. Do you have high blood pressure or high cholesterol?			
10. Do you have trouble exercising?			
11. Do your legs feel tired after standing or sitting for a long time?			
12. Have you tried over the counter medications such as Tylenol, Advil, Ibuprofen, Aleve or Aspirin for relief?			
13. Have you tried compression stocking, fitted elastic support hose, and/or compressive ACE bandages for minimum of 3-6 months?			
14. Do you have a family history of Diabetes or cardiovascular problems? (Immediate family such as Parent, sister, brother)?			
15. Have you ever experienced a stroke, mini-stroke or transient ischemic attack (TIA)?			
16. Have you had any previous surgeries or percutaneous interventions or you peripheral circulations?			
17. Have you ever had surgery to *Clean out* arteries? Neck_____ Legs _____ Abdomen_____			
18. Have you ever had any arteries bypassed surgically Heart_____ Legs _____			
19. Do you have restless leg syndrome, or painful sores or ulcers on your legs or feet that don't heal?			
20. Do you have skin redness, eczema of the legs or bleeding from varicose veins?			
21. Any other concern?			

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We recognize the need for understanding the areas of payment arrangements and insurance fillings. This sheet has been put together to address some of these areas for you.

FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding the areas of payment arrangements and insurance fillings. This sheet has been put together to address some of these areas for you.

INSURANCE, FILING/BENEFITS/PAYMENT

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make you co-payment or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered.

If we are billing your insurance for you, it is extremely important that you furnish is with accurate and updated information so you claim can be filled. It is your responsibility as a consumer to know what benefits are covered by you insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception, immunizations and other services may not be covered on your particular plan. Services provided that are not a covered benefits are your responsibility and payment is due at the time services are rendered. If you have questions as to what service is covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carried does not remit payment within 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

PAYMENT ARRANGEMENTS

Payment is expected at the time of services. If you do not have you co-pay at the time of services, your visit may be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements.

DELINQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days may be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior the 90 days in order to help us resolve this.

RETURNED CHECKS

There is a **$25.00** service fee for checks returned for insufficient funds. We belong to the Maricopa County Attorney's Check Enforcement Bureau. We request a copy of your driver's license or ID card as identification.

CANCELLATION OF APPOINTMENT/NO-SHOW APPOINTMENTS

We ask that you give us 24 hours' notice to cancel an appointment. If you do not cancel an appointment, you can be charged **$25.00** as this will be considered a no-show. Three no-show appointments are grounds for dismissal from the office.

ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment if denied for services or tests, (i.e., routine exam/lab work, vaccinations, contraception, procedures, and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

CONSENT FOR TREATMENT

I consent to evaluations and treatment of the condition for which I, or my child or dependent, have come to Phoenician Cardiac Care and authorize the physicians and other health care providers affiliated with Phoenician Cardiac Care/Phoenician Medical Center/Phoenix Neurological Institute or Phoenician Medical Center group of companies to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by PC. I authorize Phoenician Cardiac Care to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visit or episodes of evaluation and treatment at PC. **CONSENT FOR MEDICATIONS HISTORY**

CONSENT FOR MEDICATION HISTORY

I authorize Phoenician Cardiac Care to access my medication history, including controlled substances, from a drug database or prescription monitoring program. This information will be used to ensure safe and effective medical care, including accurate medication management and prevention of adverse drug interactions. I understand that my medication history, including current and past prescriptions, may be accessed. This may include controlled substances and medications obtained from other healthcare providers. The information will be used strictly for medical purposes and treated confidentially in compliance with applicable privacy laws (e.g., HIPAA)

ADVANCE DIRECTIVES

Phoenician Cardiac Care will keep a copy of my advance directive/living will/power of attorney paperwork on file if I wish to offer a copy for my chart. Phoenician will also offer paperwork to me if I am interested in advance directives. I acknowledge that I have been informed and understand Phoenician Cardiac Care policy on advance directives.

CONSENT FOR SHARED ELECTRONIC MEDICAL RECORDS

I understand PCC shares an electronic medical record system (MD Synergy/Althea) with Phoenician Medical Center/Phoenix Neurological Institute or Phoenician Medical Center group of companies. I also understand only the minimum necessary will be viewed by staff members and only for continuation of patient care.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policies of Phoenician Cardiac Care. I understand the contents and by signing below accept the aforementioned financial responsibilities

Patient/Guardian's Signature: _____ Date: _____

CURRENT LIST OF MEDICATION

Please bring a list of your current medications to your appointment as well as how many refills you have available. This way we can ensure you have enough medications to last until your next scheduled appointment. Thank you for your understanding and cooperation. By signing below, I understand and agree to this policy.

Patient/Guardian's Signature: _____ Date: _____

HIPAA CONSENT

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI WITH CONDITIONS

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

1. Persons within the physician's practice authorized to use or make disclosure of the information: ALL EMPLOYEES OF PHOENICIAN CARDIAC CARE/Phoenician Medical Center/Phoenix Neurological Institute or Phoenician Medical Center group of companies.
2. Persons or organizations authorized to receive the information:

   Spouse: Yes No If yes, list person (s) name: _____

   Parent: Yes No If yes, list person (s) name: _____

   Other individual (i.e boyfriend / girlfriend, brother, sister, etc): Yes No

   If yes, please list name (s) and relation: _____

3. Specific description of information that may be used or disclosed:
   Test results, referrals, samples, prescriptions, paperwork, medical records etc.

4. The information will be used/disclosed for the following purposes:
   A. To inform me of my medical condition (s) by phone, mail, email or in person.
   B. To give information/referrals/medical records/samples/prescription, paperwork, and or test results to you or the person (s) named on this form, by phone, mail email or in person.
   C. For treatment, payment and health care operations.

5. This authorization expires on:_____

I understand that i may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if

A. The physician has taken action in reliance of this authorization, or

B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

- ☐ I acknowledge that I have been offered a copy of Phoenician Cardiac Care Notice of Privacy Practices. I also know I can go to the website to read or print the notice online.
- ☐ I acknowledge that I declined a copy of Phoenician Cardiac Care Notice Notice of privacy Practices offered to me today.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

ADVANCE DIRECTIVES

Phoenician Cardiac Care will keep a copy of my advance directive/living will/power of attorney paperwork on file if I wish to offer a copy for my chart. Phoenician will also offer paperwork to me if I am interested in advance directives. I acknowledge that I have been informed and understand Phoenician Cardiac Care policy on advance directives.

Patient/Guardian's Signature: _____ Date: _____

Rights of the Patient: *Effective 5.1.2016 / Reviewed 1.2025*

You have the right to be treated with dignity, respect and consideration and you will not be subjected to:

* ABUSE * NEGLECT * EXPLOITATION * COERCION * MANIPULATION * SEXUAL Abuse or Assault
* RESTRAINT OR SECLUTION (except as allowed in R9-10-1012(B).
* RETAILIATION for submitting a complaint to our office, The AZDHS or any other entity.
* Misappropriation of personal or private property by a staff member, volunteer or student

You or your representative:

- Except in an emergency, either consents to or refuses treatment
- May refuse or withdraw consent for treatment before treatment is initiated
- Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of proposed psychotropic medication or surgical procedure
- Is informed of our policy on Healthcare directives
- Is informed on the patient complaint process. (See “License Posting Notice”)
- To consent to a photograph before being photographed.
- Except as otherwise permitted by law, provides written consent to the release of information in the patient’s medical record or financial records.

You have the right:

- Not to be discriminated against based on Race, National origin, Religion, Gender, Sexual orientation, Age, Disability, Marital Status or Diagnosis
- To receive treatment that supports & respects your individuality, choices, strengths and abilities
- To receive privacy in treatment and care for personal needs
- To review upon written request, your own medical record according to A.R.S 12-2293, 12-2294 & 12-2294.01
- To receive a referral to another healthcare institution if our office is not authorized or not able to provide care needed by you the patient.
- To participate or have your representative participate in the development of or decisions concerning treatment
- To participate or refuse to participate in research or experimental treatment
- To receive assistance from a family member, your representative or other individual in understanding, protecting or exercising your rights.

Responsibilities of the Patient:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To report perceived risks in your care and unexpected changes in you condition to your provider
- To ask questions if you do not understand what you have been told about your care or what you are expected to do
- To follow the treatment plan established by your provider, including the instructions of support staff as they carry out the providers orders
- To keep appointments and for notifying the office when you are unable to do so.
- For your actions should you refuse treatment or not follow your provider’s orders.
- To assure that the financial obligations of your medical care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and office staff & respectful of your personal property and that of other persons in the office.
- To have a surrogate decision maker identified if you are unable to make decisions about care, treatment or services.
- To involve the family in care, treatment and services with permission from you or your surrogate decision maker.

Signature of Patient or Representative: _____ Date: _____

NOTICE OF HEALTH INFORMATION 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 see the receptionist to request a copy.

Understanding Your Health Record/Information Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: basis for planning your care and treatment means of communication among the many health professionals who contribute to your care legal document describing the care you received means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals a source of data for medical research a source of information for public health officials charged with improving the health of the nation a source of data for facility planning and marketing a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy better understand who, what, when, where and why others may access your health information make more informed decisions when authorizing disclosure to others

Your Health Information Rights although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to: request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 obtain a paper copy of the notice of information practices upon request inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 amend your health record as provided in 45 CFR 164.528 obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528 request communications of your health information by alternative means or at alternative locations revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities This organization is required to: maintain the privacy of your health information provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you abide by the terms of this notice notify you if we are unable to agree to a requested restriction accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your health information without your written authorization, except as described in this notice. To Report a Problem If you have questions and would like additional information, you may contact this office at 480-963-1853 or email at siri@phoenicianmedical.com. If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint. Examples of Disclosures for Treatment, Payment and Health Operations Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Health Operations: 1. Risk Management - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. 2. Business Associates - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information. 3. Notification – We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition. 4. Communication With Family - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. 5. Research - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. 6. Funeral Directors – We may disclose health information to funeral directors consistent with applicable law to carry out their duties. 7. Organ Procurement Organizations – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant. 8. Marketing – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. 9. Food and Drug Administration (FDA) – We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement. 10. Workers' Compensation – We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law. 11. Public Health – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. 12. Law Enforcement – We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: January 1, 2015