Pioneer Cardiovascular
2149 E. Baseline Rd, #103, Tempe, AZ 85283
PH:(480) 345-0034 F:(480)345-4033

Patient's Name (Last) _____ (First) _____ (M.I.) _____

SS# _____ Date of Birth _____/_____/_____ Marital Status _____ Sex _____

Race :( optional) _____ Ethnicity: (optional) _____ Preferred language: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone #: _____

| **Local Address** | **Permanent/Mailing Address** |
|---|---|
| Street _____ Apt#_____ | Street _____ Apt# _____ |
| City, State, Zip _____ | City, State. Zip _____ |
| Phone (H) _____ (B) _____ | Phone (H) _____ (B) _____ |

Cell Phone _____ **Email address** _____

**Would you like to register for web portal?** ☐ Yes ☐ No

**Emergency Contact**

Name (Last) _____ (First) _____ (M.I.) _____

Phone (H) _____ (B) _____ Relationship to Patient _____

**I have read and acknowledge all of the above policies associated with Pioneer Cardiovascular Consultants, PC including: (PLEASE INITIAL)**

**_____Authorization to Release Medical Records**

**_____Financial Policy (Unless I notify the billing department, I understand I will receive e-mail statements if I provided my e-mail address.)**

**_____Acknowledgement of Privacy Practices and Advanced Directives**

**_____Privacy Notice Acknowledgement and Communication Consent**

**_____Appointment Cancellation and No Show Policy**

_____ _____

**Patient Signature/ Parent / Legally Authorized** **Date**

**Patient/Parent/Legally Authorized Printed Name**_____

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# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone Number: _____
Address: _____ Date of Birth: _____
_____

I hereby authorize the Pioneer Cardiovascular Consultants / the outside practice, to receive and/or release medical records on my behalf.

☐ All health records in your practice, related to myself

☐ Specific health information:

_____

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (480) 345-0034.

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Or as otherwise permitted by law.

_____

Signature of Patient (or Personal Representative) Relationship to Patient Date

_____

Witness Relationship to Patient Date

(REV 9/2017)

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Patient Name: _____ Date of Birth: _____

**WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY:**

_____

## DRUG ALLERGIES:

_____ _____
_____ _____
_____ _____

## CURRENT MEDICATIONS:

| | Dosage (mg) | Times per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE LIST ANY PRIOR OR CURRENT MEDICAL CONDITIONS:** (EX: HYPERTENSION, CHOLESTEROL, DIABETES, ETC.)

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

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**SURGICAL HISTORY/HOSPITALIZATIONS (Provide dates):**

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**PLEASE CHECK-MARK ANY PERTINENT FAMILY HISTORY:**

| FAMILY MEMBER: | DIABETES | HYPERTENSION | HEART DISEASE | STROKE | CANCER | OTHER: (SPECIFY) |
|---|---|---|---|---|---|---|
| MOTHER- | | | | | | |
| FATHER- | | | | | | |
| SIBLINGS- | | | | | | |

**SOCIAL HISTORY:**

**WHAT IS YOUR OCCUPATION?:** _____

**DO YOU EXERCISE? IF SO, WHAT TYPE OF EXERCISE DO YOU DO, AND HOW OFTEN?**

_____

**SUBSTANCE HISTORY:**

**ANY PAST OR CURRENT TOBACCO USE? YES / NO (Provide quantity per day/quit date if applicable)**

_____

**ANY PAST OR CURRENT DRUG USE? YES / NO** _____

**ANY PAST OR CURRENT ALCOHOL USE? YES / NO**
**Please list how often/quantity** _____

**ANY CAFFEINE USE? YES / NO** _____

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# FINANCIAL POLICY

Thank you for choosing us as your cardiologists. We are committed to providing you with quality and affordable health care. It is our policy that payment is due at the time of service unless other financial arrangements have been made. Please read this policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request. Please note that most forms of payment are accepted: credit card (MC, Visa, AmEx, Discover), debit card, check (including cashier's check or money order), and cash. There will be a $35 NSF fee charged for all checks returned for insufficient funds.

**Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please understand that you are responsible for payment even if you are expecting insurance to cover all or some portion of the payment. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-payments, deductibles and co-insurances**. All co-payments, deductibles and co-insurances must be paid at the time of service (excluding Medicare). This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurances from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Note that you may be charged for missed appointments (see separate Appointment Cancellation policy).

**Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Insofar as reasonably possible, you will be notified prior to the scheduled appointment if this is the case. Please remember that you are 100% responsible for all charges incurred; your physician's referral and/or our verification of your insurance benefits are not a guarantee of coverage. Some labs and other testing done at outside facilities may incur charges from those facilities.

**Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance

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remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In the event payment is not made on this account and it is referred to a collection agency I/We agree to pay the collection agency fee of 33% in addition to the collections balance. Any arrangements/payments will need to be paid directly with/to the collection agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**Payment Plan.** Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship. Call (480) 345-0034 for assistance.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

## PATIENT FINANCIAL AUTHORIZATION

Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

**ASSIGNMENT AND RELEASE**: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

## MEDICARE PATIENTS ONLY

**MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE**: I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me.

I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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# Appointment Cancellation & No-Show Policy

If I do not cancel my appointment prior to 24 business hours before my appointment time, I will incur a no show charge (this includes office visits, hospital procedures, and/or testing).

If I do not show up for an appointment, I will incur a $50.00 charge for office visits, $75.00 charge for testing, $100.00 charge for nuclear stress testing, and/or a $100 charge for hospital procedures. The same fee will be charged if I do not follow the testing instructions and/or give 24 business hour notice to cancel or reschedule my appointment.

I have read and understood, and agree to these policies of Pioneer Cardiovascular Consultants, PC.

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# Privacy Notice Acknowledgment and Communication Consent

Patient Name: _____ DOB: _____
*PLEASE PRINT NAME*

**Please list below the pharmacy you use including phone number, address or cross streets:**
**Name: _____ Phone: _____**
**Address/Cross Streets: _____**

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

**Can we leave detailed or confidential messages on your home phone?**
Yes ☐ No ☐ Home Number: _____

**Can we leave detailed or confidential messages on your cell phone?**
Yes ☐ No ☐ Cell Phone: _____

**Can we mail test results to your home?**
Yes ☐ No ☐

**Exclusions/Alerts** (Please note any information that you do not want released to authorized individuals:
_____
_____

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

| NAME | RELATIONSHIP | SECRET QUESTION (i.e. Mother's maiden name, city of birth, favorite color, optional) | ANSWER |
|---|---|---|---|
| 1) | | | |
| 2) | | | |

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Pioneer Cardiovascular Consultants, P.C. Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____ _____
Patient or Person Authorized to Sign If not patient, relationship to patient (parent, legal guardian, personal representative, etc.)