Colorado Heart & Vascular

Professionalism Taken to Heart

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Date:_____

Patient Information

Last Name: _____ First Name: _____ M.I:_____

Social Security #:_____ Date of Birth: _____ Gender: Male Female

Address:_____ Apt#_____ Driver's License #:_____

City:_____ State: _____ Zip Code: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Email address:_____

For the bolded questions below, please answer in the spaces provided or circle all answers that apply to you.

Race:

Asian Black/African American Native American White Other Unknown or not reported

Ethnicity:

Hispanic or Latino Not Hispanic or Latino Unknown or decline to report

Language:

English Spanish Russian Refused to Report Unreported Other

Other Physicians:

Primary Care Physician: _____ Phone Number: (_____)_____

Referring Physician: _____Phone Number: (_____)_____

Marital Status:

Married Single Divorced Widowed/Widower Life partner

Children:

Yes No Number of Sons:_____ Number of Daughters:_____

Employment Status:

Employed Retired Unemployed

Employer:_____ Occupation: _____

Address:_____ Phone number: (_____)_____

Name:_____ DOB:_____

In the space below please describe your problem(s) that you are having now. Please include when the problem first presented, how severe your problem is and any contributing factors to your ailment.

_____

_____

_____

_____

Have you ever used tobacco?

No/ Never Yes, formerly Yes, currently

Tobacco Type: Cigarettes Chewing Tobacco Pipe Tobacco Snuff

Age Started:_____ Age Stopped:_____

Quantity per Day:_____ Total years used:_____

Diabetes: Have you ever been diagnosed with diabetes? Yes No Unknown

Type: 1 2 Year Diagnosed: _____

Dyslipidemia: Have you ever had abnormal Cholesterol? Yes No Unknown

Type:_____ Year Diagnosed:_____

Family History Premature Coronary Artery Disease Has anyone in your family younger than the age of 60 had Coronary Artery Disease?

Yes No Unknown Adopted

Hypertension Have you ever been diagnosed with high blood pressure? Yes No Unknown

Year Diagnosed:_____

Peripheral Vascular Disease: Have you ever been diagnosed with PVD? Yes No Unknown

Year Diagnosed:_____

Alcohol consumption: Do you drink alcohol? Yes No

Frequency:_____ Amount:_____ Last Drink:_____

Caffeine Consumption: Do you drink/ consume caffeine? Yes No

Type(s):_____ Frequency:_____ Amount:_____

Recreational Drug Use: Do you use any drugs recreationally, including marijuana? Yes No

Type(s):_____ Frequency:_____ Amount:_____

_____ Please initial here if you consent to having confidential information in Social History Document

Name:_____ DOB:_____

In the space below, please note your family members current health status to better allow us to treat you. Specifically, please note if your family members have a history of coronary artery disease, heart attacks, high blood pressure, high cholesterol, stroke, diabetes, sudden death, heart failure and / or cancer? (Please circle Alive and Well, Alive and diagnosed or Deceased; then note the cause of death or diagnosis if known and the age at which the disease was first diagnosed)

If you were adopted please initial here_____

Father:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

Mother:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

Brother:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

Sister:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

Daughter:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

Son:
Alive and Well Alive and diagnosed Deceased
Diagnosis or Cause of Death/ Age of disease onset:_____

In the space below please include grandparents or other family members not listed above.

_____

_____

_____

Past medical history (Circle all that apply)

Heart Disease	Lung problems	Liver Disease
Heart Valve Problems	Kidney Disease	Bleeding
Blood clot in the Lungs	Thyroid disease	Pacemaker
Heart Failure	HIV disease/exposure	Heart Block
Hereditary Heart Defect	Diabetes	Previous Heart Attack
Heart Murmur	Stroke/TIA	High Blood Pressure
Blood Clot in the Legs	Asthma	Emphysema
Hepatitis (A, B, or C)	Cancer	

Comments:

_____

Name:_____ DOB:_____

Please provide information about previous SURGERIES (Include date or Year)

Coronary Bypass:_____ Date:_____

Cardiac Cath/ Angiogram/ Stent:_____ Date:_____

Pacemaker/ ICD:_____ Date:_____

Please List any Medication Allergies and Drug Reaction:

_____

_____

_____

Pharmacy Name and Phone number:_____

Please use the space below, and present at the time of your appointment, a list of all of your current medications, vitamins, and supplements. This will help us better serve you. Thank you!

Please print clearly.

Name of Medication (s)	**Dose** (Mg/ mcg/ etc)	**Amount Taken Daily** (How many tablets, caps or injections per day)

Use the back of this page as needed

Name:_____ DOB:_____

PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

I grant permission to Colorado Heart & Vascular, P.C. to disclose Health information in the following manner:

By my initials, I recognize that electronic mail is **Not** a secure form of communication.

Communicate information via electronic mail:_____

Leave a message on my voicemail/answering machine at home:_____ Phone #:_____

Leave a message on my voicemail/answering machine at work:_____ Phone #:_____

Leave a message on my voicemail on my mobile phone:_____ Phone #:_____

EMERGENCY CONTACT AND PERMISSION TO COMMUNICATE

Please fill in the following questions and circle selected options that apply to you.

Name:_____ Relationship:_____ Ph:_____
Leave Msg Ok to speak with No communication unless urgent

Name:_____ Relationship:_____ Ph:_____
Leave Msg Ok to speak with No communication unless urgent

Name:_____ Relationship:_____ Ph:_____
Leave Msg Ok to speak with No communication unless urgent

The type and amount of information that I authorize to be disclosed is as follows (please circle all answers):

Laboratory Results Radiology Results (X-rays, ultrasounds, etc.) Billing information
Prescription drug information Medical instructions or advice Insurance information
Appointment information, including confirmation/cancellation of appointment and type of appointment.

By signing this form, I understand that protected health information may be left on an answering machine as I have indicated above.

Signature of Patient or Authorized Representative

Date

Name:_____ DOB:_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review carefully!

Colorado Heart & Vascular, P.C. is permitted by Federal Privacy laws to make uses and disclosures for your health information for purposes of treatment, payment and health care operations.

We use health information about you, for your treatment, to be paid for your treatment, for continuity of care by sharing your information with other physicians involved in your total care and for various quality of care evaluations and outcome evaluations.

Our practice may contact patients to provide appointment reminders or information reminders of information about treatment alternatives or other health related benefits and service that may be of interest to you. This information may be shared by land mail, e-mail, fax, telephone, or other methods. Colorado Heart & Vascular P.C. will attempt to accommodate reasonable requests, made in writing, to communicate by alternative means or at alternative locations.

We may have to disclose personal health information about you without your authorization for public health activities; to your family if you are seriously ill and unable to communicate; for reporting abuse, neglect or domestic violence; for health oversight activities; for judicial and administrative proceeding; for law enforcement purpose; for organ donations; for coroners, medical examiners and funeral directors; for specialized government functions and to avert serious threat to health and safety.

Our practice may disclose information to research 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 protected health information.

Other uses and disclosures will be made only as otherwise required by law or with your written authorization. Such authorization may be revoked later, stop future uses or disclosures.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are physical property of Colorado Heart & Vascular P.C. The information in the records, however, belongs to you. **You have the right to:**

- Request a restriction on the use and disclosure of certain health information - **we are not required to grant the request**; unless the individual pays for the health care item or service in full on an out-of-pocket basis;
- Receive confidential information by alternative means or at alternative locations - we will attempt to accommodate reasonable requests presented to Colorado Heart & Vascular P.C. in writing;
- To inspect and obtain a copy, at normal photocopy costs, of your confidential information - if Colorado Heart & Vascular P.C. maintains the individual's PHI as an electronic health record, the individual also has the right to request and receive the PHI in electronic form - requests should be presented in writing - there may be legal exceptions to this right - you may contest the denial of access to your information by writing to Colorado Heart & Vascular P.C's HIPAA Compliance Officer;
- To request in writing that we amend your confidential information or change your demographic information. You must provide the reason for the request. We may deny your request for amendment if we determine that: we did not create the information; the law does not allow you to amend the information; your request to amend is denied, you will be told the reason and you may submit a statement showing why you disagree with the decision and this statement will be kept with your records;
- To receive an accounting of disclosures of your confidential information for uses other than disclosures of intimation for treatment, payment or healthcare operations during the prior three years;
- To receive a paper copy of the notice

Name:_____ DOB:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of Colorado Heart & Vascular, PC's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Colorado Heart & Vascular, PC's privacy practices or my rights with regard to my personal health information, I may contact your Compliance Officer at: 11700 W. 2nd Pl. Ste 350, Lakewood, CO 80228, 303-595-2727 for further information as set forth in the notice.

Printed Name of Patient or Patient Representative	Patient's Date of Birth
Signature of Patient or Patient Representative	Date

If signed by Patient's personal representative, State Representative's authority to act on behalf of the patient.

*****STAFF USE ONLY*****

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient's Date of Birth: _____

I hereby certify on _____/_____/_____ (MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of Colorado Heart & Vascular, PC's Notice of Privacy Practices, but I was unable to do so for the following reason(s).

_____

_____

_____

Name of Staff Person

_____ _____

Signature of Staff Person Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

Colorado Regional Health Information Organization

Colorado Heart & Vascular, PC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Name:_____ DOB:_____

Primary Insurance Information

Insurance Name:_____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Member ID/Policy #: _____ Group #: _____ Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: _____/_____/ _____SSN: _____ - _____ -_____ Sex: M F

Relationship to Patient _____

Secondary Insurance Information

Insurance Name:_____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Member ID/Policy #: _____ Group #: _____ Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: _____/_____/ _____SSN: _____ - _____ -_____ Sex: M F

Relationship to Patient _____

Emergency Contact (not at same address): _____ Relationship:_____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/ or surgical benefit for services rendered by Colorado Heart & Vascular, P.C. to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Colorado Heart & Vascular, P.C.

I understand that I am financially responsible for the amount not covered by insurance including, co-payments, co-insurance, and deductibles. I also agree that it is my responsibility to understand my insurance coverage and to verify that appropriate referrals, or pre-authorizations required by my insurance coverage are in place before the service is rendered. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release information necessary to secure payment. The assignment will remain in effect until revoked by me in writing.

Signature of Patient or Authorized Representative

Date

Name:_____ DOB:_____

Colorado Heart & Vascular

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Thank you for choosing us as your Specialist care provider! We are committed to providing you with premium quality, affordable health care.

INSURANCE We participate in most insurance plans, including Medicaid and 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 contact your insurance company with any questions you may have regarding your coverage.

CO-PAYS & DEDUCTIBLES All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.Please help us in upholding the law by paying your co-payment at each visit. If you have an insurance plan with a high deductible or a plan with a co-insurance, please be advised that you may be responsible for paying your insurance provider's portion (roughly half of what we bill them) until that deductible has been met. Due to the many varying complexities of each insurance plan, we are only able to provide you with an ***ESTIMATE*** of what you may owe. If in the event that you have a high deductible plan you may still have a remaining patient balance due for each visit.

NON-COVERED SERVICES Please be aware that some 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.

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 a current, valid insurance card 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.

UNVERIFIED INSURANCE COVERAGE Our office staff will attempt to verify each patient's insurance coverage at the time of service. If we cannot verify your coverage at the time of service, you will be required to pay $150.00 prior to your appointment. Once your insurance payment has been received, any remaining credits will be credited back to the card on file.

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.

Name:_____ DOB:_____

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 180 days past due for office visits, your account will be placed in collections. If your hospital account is over 90 days, you will be placed in collections. Payment plans are available and MUST be set up through the billing office. Our billing company is Aegis and their phone number is 1.888.295.3004. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. 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.

MISSED APPOINTMENTS Our policy is to charge $50.00 for missed appointments not canceled 24 hours prior to scheduled time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

RETURNED CHECKS Should your check be returned for any reason, you will be assessed a $50 returned check charge. All future balances will be payable with credit or debit card ONLY.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy, and 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 Name:_____ Date:_____

Patient Signature:_____