HRI OF AZ

THE HEART RHYTHM INSTITUTE OF ARIZONA

Medical History

Name _____ DOB _____ Age _____
Current or previous occupation _____ Retired☐Y or☐N
Marital Status○ Single ○Married ○Separated ○Divorced ○Widowed Name of Spouse _____
Race (i.e. Caucasian/Hispanic/Asian) _____
Ethnicity (i.e. American/Hispanic/German) _____
Primary Language (i.e. English/Spanish/German) _____
Primary Care Physician _____ Phone number _____
Referring Physician/Cardiologist _____ Phone number _____
Reason for visit _____

Medications

Local Pharmacy Name _____ Phone number _____
Address: _____
Mail Order Pharmacy Name _____ Phone number _____

Please list the medications you are currently taking or provide a seperate list

Medication	Dosage	How often per day?

List any allergies (medication, food, latex, inhalants or chemicals)

Allergy	Reaction

Surgeries and Procedures

Please list any previous surgeries and procedures:

Surgery _____ Surgery _____
Facility _____ Facility _____
Date _____ Date _____

Surgery _____ Surgery _____
Facility _____ Facility _____
Date _____ Date _____

_____

Name **Date**

Personal History and Risk Factors

Have you been diagnosed with any of the following?

Diabetes ☐Yes ☐No When: _____

Hypertension (high blood pressure) ☐Yes ☐No When: _____

Age>65? ☐Yes ☐No

Dyslipidemia (abnormal cholesterol) ☐Yes ☐No When: _____

What type? ○Cholesterol ○Triglycerides ○Cholesterol & Triglycerides ○Low HDL Syndrome

Peripheral Vascular Disease ☐Yes ☐No When: _____

Family history of premature coronary artery disease (Male or Female family members under 55yrs of age)

☐Yes ☐No Who: _____

Have you been hospitalized for CHF ☐Yes ☐No When: _____

History of prior Stroke ☐Yes ☐No When: _____

Please list any pertinent Family History

Adopted Yes No

Father-

Diseases _____ Age _____ Deceased _____

Mother-

Diseases _____ Age _____ Deceased _____

Brother/Sister-

Diseases _____ Age _____ Deceased _____

Child-

Diseases _____ Age _____ Deceased _____

Social History

Tobacco Usage

Current _____

Have you ever tried to quit? _____

Former _____

Year quit _____

Never _____

Type of Tobacco Use

Chewing _____ Units/Day _____

Cigarettes _____ Years used _____

Pipe _____

Passive smoke exposure? _____

Alcohol

Current _____

Former _____

Never _____

Type of Alcohol Use

Daily _____

Frequently _____

Occasionally/Social _____

Caffeine

☐Yes ☐No

Type of Caffeine use (Please circle ☐Chocolate ☐Coffee ☐Tea ☐Soda ☐Tablets ☐Energy Drinks

_____

Name **Date**

Social History Continued

Recreational Drug Use

Current _____
Former _____
Year quit _____
Never _____

Type of recreational drug use _____
Frequency _____

Activity

(Please circle) Moderate ◯ Sedentary ◯ Unable to exercise ◯ Vigorous ◯

Review of Symptoms

Are you **currently experiencing** any of the following symptoms (Please check all that apply)

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cardiac:			**Respiratory:**			**Reproductive:**		
Chest Pains			Snoring			History of oral contraception (Birth Control Pills)		
Palpitations			Hemoptysis (Coughing up blood)			**Hematologic:**		
Diaphoresis (excessive sweating)			Dyspnea (Shortness of breath)			Acute Anemia		
Syncope			**Gastrointestinal:**			Thrombocytopenia (low blood platelet count)		
Orthopnea (Difficulty breathing while laying down)			Nausea			**Endocrine:**		
PND (Breathing disorder related to CHF)			Reflux			Goiter (enlarged thyroid)		
Vascular:			Bleeding			Tremors		
Claudication (Pain or limping in legs)			**Genitourinary:**			**Derm:**		
Edema or Swelling			Hematuria (Blood in urine)			Rash		
Constitutional:			Frequent Urination at night (>2 times/night)			Skin Sores		
Weight Gain			**Neurological:**			**Musculoskeletal:**		
Weight Loss			Dizziness			Joint Pain		
Fever			Memory Loss			Myalgia (Muscle pain)		
HEENT: (Head, Ears, Nose & Throat)			Seizures					
Visual Changes			**Psychiatric:**					
Hearing Loss			Depression					
			Hallucinations					

_____

Name Date

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Patient Demographics

Last Name _____First Name _____Middle Initial _____

SSN_____ DOB _____ Sex: (Please circle) ○M ○F

Address _____ City/State/Zip _____

(Check one, if applicable) ☐ Skilled Nursing Facility ☐ Hospice Dates: _____

Race (i.e. Caucasian/Hispanic/Asian) _____

Primary Language _____

Marital Status (Please circle) ○Single ○Married ○Widowed ○Divorced ○Other _____

How may we contact you? (Please circle) ☐Home Phone ☐Cell Phone ☐Email Address

May we leave you a detailed message (Please circle) ○Yes ○No

Home Phone _____ Cell Phone _____ Other _____

Email Address

Emergency Contact Name/Relationship_____ Phone _____

Primary Care Provider _____Phone _____

Referring Provider/Cardiologist _____ Phone _____

Primary Insurance Name _____

Primary Insurance Holder Name _____DOB _____Relationship_____

Secondary Insurance Name _____

Secondary Insurance Holder Name _____ DOB _____ Relationship _____

Acknowledgment of Accuracy:

I have reviewed my personal information for accuracy. I have changed any information that is incorrect. I accept all financial responsibility that may be incurred as a result of submitting incorrect information.

_____

Signature of Patient/Guardian Date

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Consents form

Patient Name: _____ Date of Birth: _____

Do you have an Advance Directive? Yes ☐ No ☐

(An Advanced Directive is a legal document expressing your critical care wishes when you are unable to decide for yourself)

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that The Heart Rhythm Institute of Arizona has the right to change its Notice of Privacy Practices at any time and that I may contact The Heart Rhythm Institute of Arizona at any time to obtain a current copy.

Signature: _____ Date: _____

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____

Acceptance of Payment Policy and Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Payment Policy and Patient Financial Agreement.

Signature: _____ Date: _____

Acceptance of Patient Portal Authorization:

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Agreement.

Email Address:

Signature: _____ Date: _____

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Payment Policy and Patient Agreement

Welcome to The Heart Rhythm Institute of Arizona™. Our goal is to provide you quality medical care in a friendly, safe, and caring environment. We are committed to maintaining the highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations, policies, and procedures. We are committed to the care and improvement of our patients.

We consider you a partner in your own medical care. When you are well informed, when you participate in treatment decisions, and when you communicate openly with your doctor and other health care professionals, you make your care as effective as possible. You have the right to consent to or refuse a treatment as permitted by law throughout your treatment. You have the right to privacy; we will protect your privacy as much as possible as outlined in our privacy notice. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine. You are responsible for asking questions when you do not understand information or instructions. You are responsible for following instructions for your planned course of treatment.
If you believe you can't follow through with your treatment, you are responsible for telling your doctor.

FINANCIAL AGREEMENT

Timely payment for services received allows us to better manage the rising health care costs and continue to maintain the optimum standards of quality care. To ensure timely payment, we look forward to working with you to make the resolution of your account here as pleasant and comfortable as possible.

The Heart Rhythm Institute of Arizona™ requires the payment of any portion of our services that are patient responsibility at the time of service. If you are covered by an insurance plan that Executive Cardiac Arrhythmia Solutions™ participates with and the plan requires a co-pay, we will collect the co-pay at the time of service.

Please read and sign this form

1. **Payment methods**: Payments may be made by cash, check, credit card, debit card.

2. **Insurance:** The Heart Rhythm Institute of Arizona™ participates in most insurance plans, including Medicare. If you are not insured by a plan, but you are either missing an updated insurance card or you cannot provide the policy and/or group# you will be responsible. You will be required to pay for your visit in full until our office is able to confirm your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. **Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **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 your insurers. You will be billed for these services.

5. **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 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.

6. **Claims submission:** We will submit your claims and assist you in any way reasonable 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. If payment is denied due to a lack of response from you, the balance will immediately become due and payable by you. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

7. **Coverage changes:** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits.

8. **Workers Compensation:** You will be responsible for your services until your Worker Compensation claim/condition is allowed. If, after 30 days, your claim or condition has not been allowed, your bill will be due and payable in full. You will be reimbursed if and when Workers Compensation pays for your services. If there is any dispute or denial of your claim, you will be responsible for these changes.

9. **Personal Liability/Self Pay:** Personal liability or self pay patients are responsible for payment at the time of services. We will do our best to ensure that charges incurred during your visit will be will communicated prior to services being rendered.

10. **Un-Insured Patients:** If you are not insured or are not covered by a plan for which we are not providers, payment is expected at the time of services.

11. If patient balances are not paid within 90 days of receiving a statement, your account **may** be turned over to our collection agency.

12. **For New Patients**: If you are for any reason unable to keep your appointment, we would appreciate advanced notice. Repeat no show visits will result in a possible fee.

FEES NOT COVERED BY YOUR INSURANCE PLAN:

- FMLA, disability forms, or waivers, letters other than communication with your primary or cardiology provider will result in an agreed upon charge

Hospital charges and lab bills are between you and the hospital. The Heart Rhythm Institute of Arizona™ is not able to assist you with these responsibilities.

Failure to provide complete insurance information may result in patient responsibility for the *ENTIRE* bill.

I hereby authorize my insurance benefits to be paid directly to The Heart Rhythm Institute of Arizona™. I authorize the release of any medical or other information necessary to process insurance claims. Office fees, no-show fees, returned check and credit card fees and finance fees are my responsibility. By signing this agreement, it is understood that I, or as the guardian of a minor, understands and agrees to abide by our Patient Financial Policy and will accept the conditions thereof.

Patient Name (print) _____ Date of Birth _____

Signature _____ Date_____

All patients are required to sign an updated financial agreement every year.

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The Heart Rhythm Institute of Arizona™

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.

The Heart Rhythm Institute of Arizona™ (the "Practice") is 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 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 the details of your treatment, sharing your 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-hours 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 strictly 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 your 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 Communications**: 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 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 of 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 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.

If you have questions about this notice, please contact Practice's Privacy Officer:

If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.