PREMIER CARDIOVASCULAR CENTER

Patient Information Sheet

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

SSN#_____ Date of Birth ____/____/____ Marital Status_____ Sex_____

Local Address

Street_____ Apt#_____

City, State, Zip_____

Phone (H) _____ (Cell) _____

Permanent/Mailing Address

Street_____ Apt#_____

City, State, Zip_____

Phone (H) _____ (B) _____

PHARMACY: _____ Phone:_____

Email address_____
Preferred contact method: □ Call □ Text □ Email

How did you hear about us? ___Facebook ___Family/Friend ____Yelp ___Website __ other: _____

Primary Care Provider: _____

Emergency Contact

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

Phone (H) _____ (Cell) _____ Relationship to Patient_____

Primary Insurance

[ ] HMO [ ] PPO [ ] Medicare [ ] AHCCCS [ ] Marketplace
[ ] Workers Comp [ ] Other_____

Insurance Name_____

Address_____

Address_____

City, State, Zip_____

Phone_____ Eff Date____/____/_____

Policy/ID#_____ Group#_____

Policy Holder: Name_____

Relationship to Patient_____

(Policy Holder) DOB____/____/____SS#_____

Employer_____

Phone_____

Secondary Insurance

[ ] HMO [ ] PPO [ ] Medicare [ ] AHCCCS
[ ] Workers Comp [ ] Other_____

Insurance Name_____

Address_____

Address_____

City, State, Zip_____

Phone_____ Eff Date____/____/____

Policy/ID#_____ Group#_____

Policy Holder: Name_____

Relationship to Patient_____

(Policy Holder) DOB____/____/____SS#_____

Employer_____

Phone_____

Are you a resident of a: □ nursing home □ extended care facility □ skilled nursing facility □ assisted living facility?
Are you enrolled in hospice? □ Yes □ No

Patient Signature_____ Date_____

PCC Casa Grande	**803 N Salk Drive**	**Casa Grande, AZ 85122**	**520-836-6682**	**Fax: 520-836-6703**
PCC Chandler	**77 S Dobson Rd**	**Chandler, AZ 85224**	**480-814-0266**	**Fax: 480-814-0018**
PCC Maricopa	**21300 N John Wayne Pkwy Unit 116 Building 7**	**Maricopa, AZ 85139**	**520-836-6682**	**Fax: 520-836-6703**

Financial Policy and Patient Responsibility

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

Premier Cardiovascular Center's financial policy below outlines the patient and practice financial responsibilities to assist us in providing superior medical care while minimizing administrative costs. The goal of the policy is to avoid misunderstanding and disagreement regarding payment for professional services.

- PCC accepts many health insurance plans. For patients insured with an insurance plan, our office will submit claims for services provided to beneficiaries.
- **Patient's responsibility due at time of visit can include copay, coinsurance, deductible, services not covered according to your specific plan.**
- It is patient responsibility to provide us with correct insurance information and complete all necessary insurance information prior to being seen by one of our physicians
- It is patient responsibility to understand their insurance plan. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements including copay, coinsurance and/or deductibles. If you are **not** familiar with your plan coverage, it is recommended you contact your carrier directly.
- **To provide PCC with a referral/authorization for treatment** when required **prior** to the visit. Visit may be rescheduled or patient may be financially responsible due to lack of referral/authorization.
- Payments for professional services can be made by cash, check or credit card.
- Payment arrangements are available for qualified patients with financial difficulties. If a patient would like to determine if they qualify for assistance, please request contact with a patient account/billing department. Please do **not** discuss financial arrangements with physician. Patients with **no** insurance are expected to pay for professional services at the time of the visit
- PCC will require patients or family members retrieving prescription samples or medical records to present a photo ID.
- **Please provide 24 hours advance notice for cancelled appointments. All appointments cancelled without a 24 hour notice and "No Show" appointments will be charged $25.00. Nuclear stress testing charge will be $200.00**
- There will be a $25 charge on returned checks for Non-sufficient funds. Prompt payment is required by credit card or money order.
- There will be a $25 charge for completing FMLA or Disability forms
- There will be a $25 charge for copies of diagnostic images and/or CD/DVD records.
- PCC will file your primary insurance; all other insurances will be filed as a courtesy.
- Patient is responsible for balance after receipt of insurance payments. Non-payment will result in a demand letter after which balance will be forwarded to a collection agency and all collection agency costs will be the responsibility of the patient
- PCC staff will be happy to assist with any billing questions, please call 480-295-3200
- As of January 1, 2019 PCC is no longer able to prescribe narcotics or pain medications. Please see your primary care physician or pain management specialist for these medications.
- Video recording of office visits is not permitted without written consent from the provider/practice.

I have read and understand the Premier Cardiovascular Center financial policy. I authorize Premier Cardiovascular Center to obtain and/or release medical information necessary for filing insurance claims on my behalf and for the purposes of healthcare management. I authorize my insurance carriers to make payments directly to Premier Cardiovascular Center. Should insurance payment be made directly to the insured, I agree to immediately pay these funds to Premier Cardiovascular Center.

_____ _____ _____

Patient Name (please print) Signature Date

D.O.B. _____

By signing this consent form, I agree that Premier Cardiovascular Center PLC can request and use my medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. Initials _____

PREMIER CARDIOVASCULAR CENTER

Medicare Lifetime Authorization

Patient Name: _____

Medicare #:_____ Chart #:_____

Authorization Period: From _____To*_____
(*or until rescinded)

"I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me during the effective period of this authorization. I also authorize the below named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

Date: _____ Patient's signature: _____

PREMIER CARDIOVASCULAR CENTER

Medical Records Release Authorization

Please mail or fax this form to your physician(s) so we may obtain your records before your first appointment with us.

Patient Name_____ Date of Birth_____

Address_____ Phone#_____

Dates of Hospital Service_____

Purpose of Disclosure_____

I authorize the release of records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use, from the following facilities:

_____
_____
_____
_____

X All pertinent reports	□ Lab reports
□ Consultation	□ Operative
□ Discharge summary	□ Pathology report
□ EKG reports	□ X-Ray reports
□ History and physical	□ Other_____

I hereby authorize the above listed companies to release all of the requested information relative to my treatment and care to:

Premier Cardiovascular Center
803 N Salk Drive, Casa Grande, AZ 85122
Phone 520-836-6682 Fax 520-836-6703

77 S Dobson Road, Chandler, AZ 85224
Phone 480-814-0266 Fax 480-814-0018

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosure.

_____ _____
Signature of Patient Date

_____ _____
Signature of other authorized person Relationship to patient Date

*If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign.

I affirm that the patient is deceased, that no personal representative of his estate has been appointed, and that I am the patient's_____
(relationship to patient)
Signature_____ Date_____

Please mail or fax this form to your physician(s) so we may obtain your records before your first appointment with us.

PREMIER CARDIOVASCULAR CENTER

Patient Privacy

I acknowledge Premier Cardiovascular Centers Notice of Privacy Practices:

_____ _____

Patient Signature Date

May we leave phones messages *(please circle one)*:

Yes No

Preferred Contact Method: [ ] Voicemail [ ] Text Message [ ] Email

Home phone_____ Cell phone _____

Email address_____

I would like to enroll in the Patient Portal (circle yes or no):

Yes No

_____ _____

Patient Signature Date
Or Personal Representative Signature

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

If you would like any person(s) to be able to communicate with the Premier Cardiovascular Center about your care, please include their name below. You may add or subtract any person at any time.

You may discuss my care with the following person(s):

Name: _____ Name: _____

Name: _____ Name: _____

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Premier Cardiovascular Center, PLC (PCC) LEGAL DUTY:

PCC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

PCC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, PCC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

PCC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by federal, state or local law.

In any other situation, PCC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PCC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. PCC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that PCC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on PCC's health information practices or if you have a complaint, please contact the following person:

Contact Name: Asha Solsi, MD
Business Name: Premier Cardiovascular Center
Address: 77 S Dobson Road, Chandler, AZ 85224
Telephone Number: 480-814-0266
Facsimile Number: 480-814-0018