



Welcome to AHI - Payson

Dear Patient -

Welcome to the Arizona Heart Institute. Since 1971, we have been providing excellence in cardiovascular care and have earned an international reputation in the fields of patient care, medical research and education. Thank you for entrusting us with your care and for the opportunity to serve you.

Pre-Appointment Instructions:

DATE: _____ TIME: _____ DOCTOR: _____

Please read the enclosed materials and fill out the following forms before your appointment and bring them with you on your first visit. These forms include:

- Patient Information Sheet
 - Patient History
 - Acknowledgement of Privacy Practices (HIPAA)
 - Financial Policy and Patient Responsibility
 - Medicare Lifetime Authorization (for Medicare patients only)
 - Medical Records Release Form
 - Notice of Privacy Practices - describes how your medical information may be used and disclosed, and how you can get access to this information.
- ***If your insurance requires pre-authorization from your primary care physician, (i.e. AHCCCS, BC/BS HMO, Pacificare, etc.) please contact your PCP so that proper authorization is in our office prior to your appointment. This referral is your responsibility and service may be denied without it.***

Other items to bring:

- Photo identification.
- Insurance card(s) and claim forms.
- Arteriogram (dye test) and/or x-rays, CT scans performed in the past year, and a written report. These can be obtained by contacting the facility where they were performed, usually the radiology department.
- All medications you are currently taking, in the original bottles.

Your Appointment:

- Co-payments will be collected at the time of service. Visa, MasterCard and Discover are acceptable forms of payment.
- It is most helpful if you fax to our office any prior cardiac or other pertinent medical records prior to your visit. Our fax number is (928) 474-9424. If you plan to hand carry your records please notify our office.

We look forward to meeting you on your scheduled appointment time. Please, feel free to call our office at (928) 474-2175, if you have any further questions.

Thank you for choosing the Arizona Heart Institute, *the people who touch the heart.*

Arizona Heart Institute Physicians and Staff



708 Coeur D'Alene Lane, Suite B • Payson, Arizona 85541
928.474.2175 • Fax: 928.474.9424 • www.azheart.com



Patient Information Sheet

Acct# _____

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

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

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 _____

Emergency Contact

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

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

Other Physician Information

Name of Referring Physician (Last) _____ (First) _____ (M.I.) _____

Name of Primary Care Physician (Last) _____ (First) _____ (M.I.) _____

Primary Insurance

Secondary Insurance

[] HMO [] PPO [] Medicare [] AHCCCS
[] Workers Comp [] Other _____

[] HMO [] PPO [] Medicare [] AHCCCS
[] Workers Comp [] Other _____

Insurance Name _____

Insurance Name _____

Address _____

Address _____

Address _____

Address _____

City, State, Zip _____

City, State, Zip _____

Phone _____ Eff Date ____/____/____

Phone _____ Eff Date ____/____/____

Policy/ID# _____ Group# _____

Policy/ID# _____ Group# _____

Policy Holder: Name _____

Policy Holder: Name _____

Relationship to Patient _____

Relationship to Patient _____

(Policy Holder) DOB ____/____/____ SS# _____

(Policy Holder) DOB ____/____/____ SS# _____

Employer _____

Employer _____

Phone _____

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 _____



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:

- | | | |
|-------|--|---|
| _____ | <input type="checkbox"/> All pertinent reports | <input type="checkbox"/> Lab reports |
| _____ | <input type="checkbox"/> Consultation | <input type="checkbox"/> Operative report |
| _____ | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Pathology report |
| _____ | <input type="checkbox"/> EKG reports | <input type="checkbox"/> X-Ray reports |
| _____ | <input type="checkbox"/> History and physical | <input type="checkbox"/> Other _____ |

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

Arizona Heart Institute
708 Coeur D'Alene Lane, Suite B, Payson Arizona 85541
Phone: (928) 474-2175, Fax: (928) 474-9424

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 _____

*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 _____



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Financial Policy and Patient Responsibility

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

Patient's Responsibility:

To know their insurance policy: Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements and cost share information including copay, coinsurance and/or deductibles. If you are not familiar with your plan coverage, it is recommended you contact your carrier directly.

To promptly pay patient responsibility indicated by your insurance: The balance can include copay, coinsurance, deductible, services not covered according to your specific plan.

To obtain a referral or authorization from your Primary Care Physician (PCP): For treatment from your insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.

To participate in claims payment by contacting your insurance carrier: If the claim is not paid within 60 days, the balance would be transferred to the patient for assistance.

Arizona Heart Institute Policy:

- In lieu of a finance charge on unpaid patient balances a collection agency fee will be added to accounts not paid that are referred to an outside collection agency.
- 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.
- AHI will file your primary insurance; all other insurances will be filed as a courtesy. AHI will allow 30 days for payment. After 30-days, the balance will become patient responsibility.
- A 60-day period will be extended for pending primary insurance payments after which the patient could be held responsible for the balance.

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage, I will be financially responsible for the portion not covered by my insurance. I understand that payments can be by cash, check or credit card (MasterCard, Visa, Discover or American Express) I agree that if my account is referred to a collection agency or attorney, I am responsible for any cost including attorney's fees or interest.

Patient Name (please print)

Signature

Date

Release of Medical Information and Assignment of Benefits:

I authorized the release of medical information necessary for filing health insurance claims forms for me by Arizona Heart Institute. I authorize my insurance carriers to make payments directly to Arizona Heart Institute.

I understand that the physicians practicing at a non Arizona Heart Institutes facility and non Arizona Heart Institute physicians including emergency room physicians, radiologists, pathologists, anesthesiologists and other physicians are independent medical practitioner and not agents or employees of Arizona Heart Institute. I understand that the AHI can not control the healthcare or services rendered by any facilities and/or physician. I understand that I will be billed separately for physician services.

Patient Name (please print)

Signature

Date



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: _____



Acknowledgement of Privacy Practices

Notice and Acknowledgement of Privacy Practices:

I acknowledge that I have received, been offered, or reviewed the Arizona Heart Institute's Notice of Privacy Practices.

Patient Signature
Or Personal Representative Signature

Date

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 Arizona Heart Institute 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: _____



Patient History

Date: _____ Chart #: _____

Name: _____ DOB: _____ Age: _____

Occupation: _____ Retired: Y or N

Referring Doctor: _____

Reason for Visit (history of present illness):

Risk Factors

Diabetes No Yes Year diagnosed _____
What type _____

High Cholesterol No Yes Year diagnosed _____

High Blood Pressure No Yes Year diagnosed _____

Peripheral Vascular Disease No Yes

Family History of Premature Coronary Artery Disease
(diagnosed under age 55) No Yes

Previous Medical History

Have you ever experienced or have been diagnosed with the following?

Congestive Heart Failure (CHF) No Yes Year diagnosed _____

Heart Attack (Myocardial Infarction) No Yes Year Diagnosed _____

Have you had surgery related to this illness? No Yes When _____
What procedure was performed? _____

Stroke No Yes Year Diagnosed _____

Have you had surgery related to this illness? No Yes When _____
What procedure was performed? _____

Cancer No Yes Year diagnosed _____

What type? _____
Have you had surgery related to this illness? No Yes When _____
What procedure was performed? _____

Previous Medical History

Lung Disease No Yes Year diagnosed _____

What type? _____

Have you had surgery related to this illness? No Yes When _____

What procedure was performed? _____

Thyroid Disorder No Yes Year diagnosed _____

What type? _____

Have you had surgery related to this illness? No Yes When _____

What procedure was performed? _____

Heart Valve Disease No Yes Year diagnosed _____

Have you had surgery related to this illness? No Yes When _____

What procedure was performed? _____

Other Major Illness or Surgical Procedures: _____

Social History

Marital Status:

Single Married Life Partner Divorced Legally Separated Widowed

Do you have children? Yes No

Number of Sons: _____ Number of Daughters: _____

Race:

Caucasian African American Hispanic Native American

Asian Pacific Islander Other: _____

Do you follow a specific diet such as:

Regular Low-cal/low-fat Low Salt Low carbohydrate

Diabetic Vegetarian Other: _____

Do you exercise? Yes No

What type? _____

Sedentary Occasional Regular Active lifestyle Physically unable to exercise

Social History

Do you use tobacco? Yes No

Type _____ Quantity/day _____ Former (Year Quit _____)

Do you use alcohol? Yes No

Frequency: _____

Former: ____ Year Quit: ____

Caffeine? - Do you drink/eat caffeine products? Yes No

What type? Coffee Tea Soda Chocolate Tablets

Drug use/abuse? Yes No Former (Year Quit _____)

Do you have advance directives on file?

None Healthcare proxy Living will Do not resuscitate

Family History

Other major health problems in your family history:

Health problem: _____

Relation: _____ Age at death: _____

Health problem: _____

Relation: _____ Age at death: _____

Health problem: _____

Relation: _____ Age at death: _____

Health problem: _____

Relation: _____ Age at death: _____

Health problem: _____

Relation: _____ Age at death: _____

Health problem: _____

Relation: _____ Age at death: _____

Medications

Are you allergic to any medications? Yes No

Medication	Reactions
_____	_____
_____	_____
_____	_____
_____	_____

Other allergies (foods, adhesive tape, iodine, latex, etc):

Current medications:

Medication	Dosage	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins and Supplements:

Vitamin/Supplement	Dosage	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

Check only the problems you are currently experiencing:

Cardiac

- Chest Pain
- Excessive perspiration
- Palpitations
- Loss of consciousness

Vascular

- Limp (claudication)
- Swelling

Constitutional

- Weight gain
- Weight loss
- Fever

HEENT

- Vision changes
- Hearing loss

Respiratory

- Snoring
- Coughing up blood
- Shortness of breath

Gastrointestinal

- Nausea
- Reflux
- Bleeding

Genitourinary

- Blood in urine
- Urinate during sleep

Neurology

- Dizziness
- Memory loss
- Seizures

Psychiatry

- Depression
- Hallucinations

Hematology

- Anemia
- Easy bruising

Endocrine

- Goiter
- Tremors

Musculoskeletal

- Joint pain
- Muscle weakness

Physician Signature

Date





Notice of Privacy Practices

Notice of Privacy Practices for Arizona Heart Institute (referred to in this document as “the provider”)

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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The provider may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Provider has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

A. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment: Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to

demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations: We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the provider and to provide quality care to all patients. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Employee review activities.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities. Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.
- Business management and general administrative activities

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures: As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment.
- To inform you of potential treatment alternatives or options.
- To inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required: We will disclose your protected health information when we are required to do so by any Federal, State or local law.

B. When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Abuse, Neglect Or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We

will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena in some circumstances.

III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information: You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the provider uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our

professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

B. The right to obtain a paper copy of this notice: Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The provider is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the provider changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated.

You may complain to the provider by contacting the Privacy Contact using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be refused treatment or retaliated against in any way for filing a complaint.

**Arizona Heart Institute
ATTN: Privacy Contact
2632 North 20th Street
Phoenix, AZ 85006**

**Telephone: (602) 266-2200
Fax: (602) 240-6160**

VIII. Effective Date - This Notice is effective April 14, 2003.
Revision Date: August 6, 2008.

