Name: _____ Date of Birth: _____

Name: _____**Gender**: Male Female **Last 4 of SS #:** _____

Date of Birth: _____ **Place of Birth**:_____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone Number: _____ **Cell Phone**: _____

Work Number: _____ **Email**: _____

What is the best way to contact you? _____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Declined to specify

Race:

- ☐ Asian
- ☐ Black or African America
- ☐ Native American Indian
- ☐ Native American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White

Preferred Language: _____

Would you like to have a translator free of charge provided during your office visits: Yes No

Religion:_____

Do you have an advance directive?

- ☐ Living will
- ☐ Medical Durable Power of Attorney
- ☐ Do Not Resuscitate
- ☐ CPR Directive
- ☐ MOST form
- ☐ Other

Name: _____ Date of Birth: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone: _____

Work Number: _____ Email: _____

Medical Care:

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Employment: *Are you retired? Yes No (if yes please skip to insurance information)*

Employer's Name: _____Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Spouse Employer's Name: _____Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Information:

Please bring the most updated insurance card(s) to your visit.

Primary Insurance: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder Name : _____ Policy Holder DOB: _____

Policy Holder SSN: _____Insurance ID #: _____Group #: _____

Name: _____ Date of Birth: _____

Reason for your visit: _____

Medications: *Please bring a list of CURRENT medication to your visit; include name, dose, and frequency of medication (please include any over the counter medications).*

Allergies and reactions:

_____

_____

_____

_____

Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Lifestyle

Diet

- ☐ Well Balance
- ☐ Vegetarian
- ☐ Diabetic
- ☐ Weight Loss/Fad
- ☐ Excessive Fat / Calories

Do you consume caffeinated products? Yes No

Type_____ Amount_____

Do you consume alcohol? Never Former Current (former and current fill in information below)

Type_____ Amount_____

Frequency:_____ Year quit:_____

Do you exercise regularly? Yes No

Type: _____ Frequency: _____

Do you use tobacco? Never Former Current (former and current fill in information below)

Type: _____ Packs/day_____ Years Used: _____

Age started: _____ Age stopped: _____

Ever try to quit: Yes No Years quit: _____ Reason for Relapse: _____

Are you exposed to passive smoke (second-hand)? Yes No

Name: _____ Date of Birth: _____

Have you used illicit drugs? Never Former Current (former and current fill in information below)

Type_____ Amount_____

Frequency:_____ Year quit:_____

Family History of Heart Disease Yes No (If yes, complete the information below.)

Relationship: _____ Age: _____ Type of Heart Disease:_____

Age of Death? _____ Cause of Death? _____

Relationship: _____ Age: _____ Type of Heart Disease:_____

Age of Death? _____ Cause of Death? _____

Relationship: _____ Age: _____ Type of Heart Disease:_____

Age of Death? _____ Cause of Death? _____

Have you had any of the following Cardiac Studies?

Echo or Stress Echo	Yes	No	When: _____	Where: _____
Nuclear Cardiac Study	Yes	No	When: _____	Where: _____
Calcium Score	Yes	No	When: _____	Where: _____

If you have a copy of any past medical history and/or test result(s) please bring them to your appointment or drop off at our office prior to your appointment.

Please list any recent hospitalizations and/or surgery and ALL cardiac procedures:

_____ When: _____ Where: _____

_____ When: _____ Where: _____

_____ When: _____ Where: _____

_____ When: _____ Where: _____

_____ When: _____ Where: _____

Name: _____ Date of Birth: _____

Have you ever had any of the following?

Abnormal EKG	Yes	No	When: _____
Aneurysm	Yes	No	When: _____
Aortic Valve Replacement	Yes	No	When: _____
Asthma	Yes	No	When: _____
Atrial Fibrillation (A-fib)	Yes	No	When: _____
Cancer	Yes	No	When: _____
Clotting Disorder	Yes	No	When: _____
Congenital Heart Disease	Yes	No	When: _____
COPD	Yes	No	When: _____
Coronary Artery Disease (CAD)	Yes	No	When: _____
Deep Vein Thrombosis (DVT)	Yes	No	When: _____
Diabetes Mellitus (DM)	Yes	No	When: _____
Heart Failure	Yes	No	When: _____
Heart Murmur	Yes	No	When: _____
Heart Value Problem	Yes	No	When: _____
Hyperlipidemia (High Cholesterol)	Yes	No	When: _____
Hypertension (High Blood Pressure)	Yes	No	When: _____
Kidney Disease	Yes	No	When: _____
Mitral Valve Disease	Yes	No	When: _____
Myocardial Infarction (Heart Attack)	Yes	No	When: _____
Pulmonary Embolism (PE)	Yes	No	When: _____
Sleep Apnea	Yes	No	When: _____
Stroke (CVA/TIA)	Yes	No	When: _____

Colorado Springs Cardiology

Date:_____

Communication Approval

Dear Patient:

Colorado Springs Cardiology is committed to protecting your privacy and the confidentiality of your medical records. In confirming our position, we comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA) as well as the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH ACT)

Copies of our Notice of Privacy Practices are available for your review upon your request. Portions of the Act require that we verify and confirm who we are communicating with when discussing your care. Please help us by providing the following information:

Patient Name: _____Date of Birth:_____
(Please Print)

Phone: Home _____Work_____Cell_____

HIPAA/HITECH grants us permission to share information with your other healthcare providers and to you the patient.

This form, however, is not an Authorization to Release Protected Health Information (PHI); it is a form that identifies individuals you, the patient allow us to share your PHI with. By signing below, you specifically exclude anyone you did not list. This includes all communications, including but not limited to statements, phone conversations, electronic data, progress reports, lab results and prescription refills. This permission remains in effect until you, or authorized people (power of attorney) alter or revoke in writing.

Please list those who we have permission to communicate your PHI with:

Name	Phone Number	Relationship

May we leave a recorded message on the phone numbers you provided? Yes/No

May we take your picture to help identify you in your electronic chart? Yes/No

By signing below you agree that you are aware of Colorado Springs Cardiology/Centura privacy policies and that the Notice of Privacy Practices is available upon request.

Patient Signature:_____Date:_____

7/21/2016

COLORADO SPRINGS CARDIOLOGY, A CENTURA CLINIC
Financial Policy

Patient Name:_____ **Date of Birth:**_____

Welcome to Colorado Springs Cardiology! Thank you for choosing us to provide your care and services. We would like to inform you of our payment policies. We accept cash, credit cards and personal checks for payment. Be aware that you may often receive two different bills when testing occurs, one from the doctor that reads the test, and one from the performing facility.

No Insurance/Non Contracted Insurance: If you have no insurance, we expect payment for your visit at the time of service. Non-contracted insurance will be billed if appropriate insurance information is given, however, some payment will be expected at the time of service. Please ensure we are listed as a contracted provider under your plan by calling your insurance company. We can't guarantee that we are contracted with your plan due to new policies being created by your insurance. The cost to see a provider for self-pay or non-contracted providers is between $135 - $200 with the cash discount. If testing is done, there are additional charges. We request that you visit with the Financial Department prior to your appointment to discuss payment. They can be reached at 719-776-8588.

Referral/Authorizations: If your insurance requires an authorization/referral to be seen by a specialist it will have to be obtained from your Primary Care Provider prior to your appointment. **It is your responsibility in obtaining this referral from your Primary Care Provider.**

Medicare: Our doctors are participating providers for the Medicare Part B program. If you have a secondary or supplemental plan, we will submit claims after payment from Medicare; however, we must have a copy of your card and the appropriate information.

Medicare Advantage Plans: We participate with most Medicare HMOs and Advantage Plans. You may be required to have a referral for your services. Please be sure there is one on file when you visit. All co-pays must be paid at the time of service. ***Please ask for a list of current non-participating insurance plans which include Kaiser Select, some BCBS plans and Humana Medicare HMO.***

Medicaid and Medicaid HMO: We do participate with the Medicaid program. *You must provide us with a copy of Your Medicaid card indicating that you are eligible for Medicaid at the time of service.* Should services be rendered, and you are no longer eligible for Medicaid coverage, you will be responsible for payment. All co-pays must be paid on the day of service.

Commercial Insurance (HMO, PPO, EPO, and POS): If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including deductible and coinsurance. If your coverage is denied for any reason, you are responsible for payment.

Auto and Workers Compensation: We will bill your auto or workers compensation for your auto or work related injury. We will need the claim number, the name of your insurance, the name and phone number of your adjuster. If your carrier determines it is not work related, we will then bill you directly or your health insurance.

Colorado Indigent Care Program: As you know when you were approved for CICP, you were told this is a financial assistance program based on income and only covers outpatient or inpatient hospital services; this is not an insurance plan. **Your office visit today is not covered by this program.** However, we will be glad to see you with a cash payment up front. You will be required to show a current CICP card. We expect payment at the time of service and will allow for a cash discount at that time of service unless other arrangements were made with our Financial Dept. prior to the appointment.

Please read and sign on back

Tricare/Tricare for Life: We accept all Tricare plans. However, they may require an authorization for every appointment. Please be sure there is one on file when you visit. Tricare for Life is a secondary plan and no authorization is required.

Ancillary Services: We try to arrange for labs, radiology and any other testing to be provided at a facility which participates with your insurance. However, with the constantly changing insurance contracts and plans we are not always aware of changes made to these participation lists. ***As the insured, please notify us of any concerns as it is your insurance and your responsibility to know what facilities your insurance participates with to lower your costs.***

Missed Appointments: When we schedule your appointment, this is your time that has been reserved for you. We cannot fill that space if you do not notify us in advance of your inability to make the appointment. We request a 24-hour notice. Please look for the addendum – Late Policy and Appointments.

Physician Assistants and Nurse Practitioners: Please understand that a physician is often on call for emergent situations and may be pulled away from the clinic unexpectedly. We don't want this to happen, but when dealing with someone's heart it goes with the territory. If your physician has to leave unexpectedly, or is not available for the next appointment time you need, we may ask you to see one of the PA's or NP's that work directly with your doctor. All information received during your office visit is sent directly to your physician for review. This information is sent immediately after your visit. The NP or PA may even call the physician directly for consultation and additional information. You can be assured that your physician is looking and is aware of what is going on with you personally. We have hired the top of their class PA's and NP's. They are familiar with cardiac medications, tests and symptoms and are capable of answering or getting the answer to all of your questions.

Assignment of Benefits and Authorization to Release information: I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carrier(s) including private insurance, and other health / medical plan to issue payment check(s) directly to Colorado Springs Cardiology, a Centura Health Clinic for services rendered to me or my dependents regardless of my insurance benefits, if any.

I authorize Colorado Springs Cardiology, A Centura Health Clinic to furnish and/or release any information necessary to insurance carrier(s) concerning my illness or treatment to process my insurance claims and a photocopy of my signature can be used to process my insurance claim(s) for the period of a lifetime. This order will remain in effect until revoked in writing.

I have requested medical services from Colorado Springs Cardiology, a Centura Health Clinic on behalf of my dependents or I and I understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

In the event my account becomes delinquent, I will be responsible not only for the charges incurred but also any costs involved in collection of my account. These include but are not to be limited to interest charges, re-billing fees, court costs, attorney fees, and collection costs. Insurance coverage is a matter between me and my insurance company. **I am ultimately responsible for the payment of my account.**

I understand my responsibility for payment to Colorado Springs Cardiology, A Centura Health Clinic.

_____

Signature Printed Name (Responsible Party over 18 years old) Date