Southwest CVA
Cardiovascular Associates

480-945-4343
140 South Power Road
Mesa, AZ 85206

▼ 01 - PATIENT INFORMATION ▼

How Did You Find Us? _____

PATIENT NAME: _____ _____ _____ **AGE:** _____
First *Middle* *Last*

PRIMARY *(AZ)* **ADDRESS:** _____ _____ _____ _____
Street Address *City* *State* *Zip*

SECONDARY ADDRESS: _____ _____ _____ _____
Street Address *City* *State* *Zip*

PHONE: _____ ☐*Home* ☐*Cell* ☐*Other* **PHONE:** _____ ☐*Home* ☐*Cell* ☐*Other* ***E-MAIL:** _____
**News Letters & Informative Updates*

BIRTH DATE: _____ - _____ - _____ **SOC. SEC.** *(or SIN)* **#:** _____ - _____ - _____
Month *Day* *Year*

ETHNICITY: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown **GENDER:** ☐Male ☐Female

RACE: ☐American Indian/Alaskan Native ☐Black/African American ☐Asian ☐White/Caucasian ☐Other Race ☐Unknown
☐Native Hawaiian/Pacific Islander

MARITAL STATUS: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed ☐Life Partner ☐Other Relationship

EMPLOYMENT: ☐Full-Time ☐Part-Time ☐Not Employed ☐Retired ☐Student Full-Time ☐Student Part-Time

(If Employed) **EMPLOYER NAME:** _____ *(If Employed)* **WORK PHONE:** _____

(If Employed) **EMPLOYER ADDRESS:** _____ _____ _____ _____
Street Address *City* *State* *Zip*

(Do Not Use Dr Jost) **FAMILY** *(AZ)* **DOCTOR:** _____ _____ **REFERRING DOCTOR:** _____ _____
Dr First Name *Dr Last Name* *Dr First Name* *Dr Last Name*

▼ POLICY HOLDER INFORMATION ▼

POLICY HOLDER/INSURED/GUARANTOR

(If Patient, check here ☐ and skip to Insurance Information)

GUARANTOR NAME: _____ _____ _____ **GENDER:** ☐Male ☐Female
First *Middle* *Last*

BIRTH DATE: _____ _____ _____ **RELATIONSHIP TO PATIENT:** ☐Parent ☐Spouse ☐Employer ☐Child ☐Life Partner ☐Other _____
Month *Day* *Year*

▼ INSURANCE POLICY INFORMATION ▼

PRIMARY INSURANCE: _____ **EFFECTIVE DATE:** _____

POLICY ID #: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: _____ **EFFECTIVE DATE:** _____

POLICY ID #: _____ **GROUP NUMBER:** _____

▼ INSURANCE AGREEMENT ▼

†By signing my name below, I hereby give permission to treat me and/or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have.

†I authorize the release of any medical information necessary to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

† _____ _____
PATIENT SIGNATURE **DATE**

Southwest CVA
Cardiovascular Associates

480-945-4343
140 South Power Road
Mesa, AZ 85206

140 S. Power Road Ste 102
Mesa, Arizona 85206-5297

480-945-4343 office 480-945-4350 fax

02 - PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

Do you currently have or recently have had any of the following symptoms?

CARDIOVASCULAR		
High Blood Pressure	☐Yes	☐No
Heart Murmur	☐Yes	☐No
Chest Discomfort	☐Yes	☐No
Fluttering Feeling in Chest	☐Yes	☐No
Skipped Heartbeats	☐Yes	☐No
Swelling in Ankles/Feet	☐Yes	☐No
Varicose Veins	☐Yes	☐No

CONSTITUTIONAL		
Significant Weight Loss	☐Yes	☐No
Significant Weight Gain	☐Yes	☐No
Night Sweats	☐Yes	☐No
Unexplained Fever	☐Yes	☐No

ENDOCRINE		
Thyroid Problem	☐Yes	☐No

EAR/NOSE/MOUTH/THROAT		
Difficulty Swallowing	☐Yes	☐No
Dry, Hoarse Throat	☐Yes	☐No

EYES		
Blurred/Double Vision	☐Yes	☐No
Cataracts	☐Yes	☐No
Glaucoma	☐Yes	☐No

GASTROINTESTINAL		
Indigestion/Nausea	☐Yes	☐No
Ulcers	☐Yes	☐No
Diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Abdominal Pain	☐Yes	☐No

GENITOURINARY		
Loss of Bladder Control	☐Yes	☐No
Blood in Urine	☐Yes	☐No

HEMATOLOGY/LYMPHATIC		
Breast Masses/Lumps	☐Yes	☐No
Enlarged Lymph Nodes	☐Yes	☐No
Unexplained Bruising	☐Yes	☐No

INTEGUMENTARY		
Skin Rash	☐Yes	☐No

MUSCULOSKELETAL		
Arthritis	☐Yes	☐No
Back Pain	☐Yes	☐No
Muscle Weakness	☐Yes	☐No
Leg Pain	☐Yes	☐No

NEUROLOGICAL		
Headaches/Migraines	☐Yes	☐No
Memory Loss	☐Yes	☐No
Speech Problems	☐Yes	☐No
Dizziness/Fainting Spells	☐Yes	☐No
Stroke	☐Yes	☐No

PSYCHOLOGICAL		
Depression	☐Yes	☐No
Anxiety	☐Yes	☐No
High/Unusual Stress	☐Yes	☐No
Eating Disorder	☐Yes	☐No

RESPIRATORY		
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Chronic Cough	☐Yes	☐No
Wheezing	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
History of Tuberculosis	☐Yes	☐No
Valley Fever	☐Yes	☐No
Lung Disease	☐Yes	☐No

PATIENT NAME _____ DATE _____

Southwest CVA
Cardiovascular Associates

480-945-4343
140 South Power Road
Mesa, AZ 85206

03 - PATIENT MEDICAL HISTORY

Please check all medical issues you have now or have had in the past:

Heart Disease	☐Yes	☐No	**Heart Murmur**	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	**Stroke**	☐Yes	☐No
Renal *(Kidney)* **Failure**	☐Yes	☐No	**Diabetes**	☐Yes	☐No
Lung Disease	☐Yes	☐No	**Anesthesia Problems**	☐Yes	☐No
Intestinal Disease	☐Yes	☐No	**Valley Fever/TB**	☐Yes	☐No
Thyroid Disease	☐Yes	☐No	**Drug Abuse**	☐Yes	☐No
Asthma/Emphysema	☐Yes	☐No	**Cancer**	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	*If Yes, Type of Cancer:* _____		

SURGICAL PROCEDURES & OPERATIONS

Please list all previous surgical procedures and operations including dates for each:

TYPE OF PROCEDURE	DATE	TYPE OF PROCEDURE	DATE

PATIENT FAMILY HISTORY

Has anyone in your immediate, biological family ever had any of the following?
(Grandparents, Parents, Sisters and/or Brothers)

Heart Disease	☐Yes	☐No	**Heart Murmur**	☐Yes	☐No
If Yes, Who? _____			*If Yes, Who?* _____		
High Blood Pressure	☐Yes	☐No	**Stroke**	☐Yes	☐No
If Yes, Who? _____			*If Yes, Who?* _____		
Bleeding Disorders	☐Yes	☐No	**Diabetes**	☐Yes	☐No
If Yes, Who? _____			*If Yes, Who?* _____		
Renal *(Kidney)* **Failure**	☐Yes	☐No	**Valley Fever/TB**	☐Yes	☐No
If Yes, Who? _____			*If Yes, Who?* _____		
Lung Disease	☐Yes	☐No	**Cancer**	☐Yes	☐No
If Yes, Who? _____			*If Yes, Who and Type of Cancer?* _____		

Please inform our office staff of any Living Will, Advanced Directive or Do Not Resuscitate guidelines that you may have and supply our office with a copy for your records.

_____ _____
PATIENT NAME **DATE**

Southwest CVA
Cardiovascular Associates

480-945-4343
140 South Power Road
Mesa, AZ 85206

480-945-4350 fax

CURRENT MEDICATION LIST

_____
Date

I, _____, understand that Dr. Jost and Dr. Weinstein rely on medication information I provide to them for my care, and that any medication misinformation can result in hospitalization or death. By signing this, I confirm the medication information I am providing here is accurate and complete. _____ _____
Patient Signature *Birth Date*

PATIENT ALLERGIES

Drug or Medication Allergies: ☐YES ☐NO	
Allergic to Mold, Pollen, Dust: ☐YES ☐NO	

PATIENT SMOKING HISTORY

Any Past Tobacco Use? ☐YES ☐NO	If YES, Type of Tobacco Use: _____
Do You Smoke Now? ☐YES ☐NO	If YES, # Cigarettes a Day? _____
	Quit Smoking on Date: _____

30 DAY PHARMACY	90 DAY PHARMACY	MEDICATION ALLERGIES	ALLERGIC REACTION

RX CARD INFORMATION

BIN# **GROUP#** **PCN#** **PHONE#** _____

CURRENT MEDICATIONS

MEDICATION NAME	AMOUNT/ DOSAGE	# TIMES TAKEN DAILY	ORDERING DOCTOR	START DATE

Southwest CVA
Cardiovascular Associates

480-945-4343
140 South Power Road
Mesa, AZ 85206

MEDICATIONS	AMOUNT/ DOSAGE	# TIMES TAKEN DAILY	ORDERING DOCTOR	START DATE

Authorization for Disclosure and Release of Medical Records

This form is used to request the release of Medical Records from Southwest Cardiovascular Associates (SWCVA).

Patient Name: _____ Phone Number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Physician or Name of Authorized Person(s):

_____

Address: _____
Contact Phone Number: _____
Fax Number: _____

Please check and complete all that apply:

All Medical Records

Medical Records with Specific Date(s)_____

[type] Imaging and Area for Date(s) of: _____

Other, please be specific: _____

Choose one method for receiving medical records:

Pick up at clinic location. Provide location name: _____

Mail to _____

**Email:* _____

**By requesting your medical records to be sent through unencrypted email, you understand the potential and unforeseeable risk. Initial____.*

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may be revoke this authorization at any time by giving oral or written notice to SWCVA. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released, SWCVA cannot retrieve them and has no control over the use of the already released copies. I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

There may be fees associated in providing copies of medical records. Initial_____.

Please Note:

The attached medical information pertaining to _____ is confidential and legally privileged. SWCVA has provided it to _____ as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law. I hereby release SWCVA from any and all liability which may arise as a result of my authorized release of records. I understand that SWCVA, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I have read this authorization and acknowledge the terms and conditions.

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

(*Attach copy of documentation authorized as patient legal representative.)

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the patient to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.

Revised Date	Author

Authorization to Release Medical Records to Southwest Cardiovascular Associates (SWCVA)

I hereby authorize _____, located at_____,
Healthcare Provider Name *Address*
to release my Medical Records and/or [type of record] records to Southwest Cardiovascular Associates.

Patient's Name: _____Phone number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Medical Records are to be sent to: _____
Provider Name and Address

Fax Number records to be faxed to: _____

Please check and complete all that apply.
Medical Records for Date(s) of: _____
[Type] Imaging and Area for Date(s) of: _____
Other, please be specific: _____

Health Information to being disclosed for the following purpose: (check all that apply)

Change in Insurance or Healthcare Provider
Continuation of Care

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may be revoke this authorization at any time by giving oral or written notice to SWVA. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released to SWCA, my revocation cannot be effective to the extent which the healthcare provider has taken the action and with the reliance of this Authorization.

I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I understand that SWCVA may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I have read this Authorization and I acknowledge being familiar and fully understand it's terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Personal Representative and Relationship Telephone Number

Reference Number

Revised Date	*Author*

Notice of Privacy Practice

Effective Date April 7,2017

This Notice Describes How Medical Information About You May Be Used, Disclosed and How You Can Get Access to This Information. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer at 480-945-4343.

Our Pledge Regarding Medical Information.

We understand that medical information about you and your health is personal. We are committed to protecting medical information in a reasonable and appropriate manner. We create a record of the care and the services you receive at Southwest Cardiovascular Associates (SWCVA). We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You. The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- For Treatment. We can use your health information and share it with other professionals who are treating you.
- For Payment. We can use and share your health information to bill and get payment from health plans or other entities.
- For Health Care Operations. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- Individuals Involved In Your Care or Payment for Your Care. When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- Research. Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- As Required By Law. We can share and disclose Health Information about you when required to do so by federal, state or local laws.
- To Advert a Serious Threat to Health or Safety. We can share and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- For All Other Uses and Disclosures. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.

- Organ and Tissue Donation. We can share health information about you with organ procurement organizations.
- Workers' Compensation, Law Enforcement and Other Government Agencies. We can share health information about you for workers' compensation, for law enforcement purpose and healthcare oversight agencies for activities authorized by the law, or special government functions such as military, national security and presidential protection.
- Public Health Risks. We can share Health Information about you for certain situations:
    - to prevent or control disease;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products that they may be using;
    - notify a person who may have been exposed to a disease or may be at risk.
- Lawsuits and Legal Disputes. We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- Comply with the Law. We will share information about you if state or federal laws require it, including with Health and Human Services should it want to see we are complying with federal privacy law.
- Coroners, Medical Examiners and Funeral Directors. We can share Health Information to a coroner, medical examiner or funeral director when an individual die.

Uses and Disclosures That Require Us To Give You An Opportunity To Object and Opt Out.

In these cases, you can tell us what we can share:

1. Share information with your family, close friends, or others involved in your care.
2. Share information in a disaster relief situation
3. Include your information in a hospital directory
4. Contact you for fundraising efforts. We may contact you, but you can tell us not to contact you again.

Your Written Authorization Is Required For Other Uses And Disclosures.

In these cases, we never share your information unless you have given us written permission:

1. Marketing Purposes
2. Sale of your information
3. Sharing of psychotherapy notes

*If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But any disclosure that we made in reliance on your authorization **before** you revoked it will not be affected by the revocation.*

Your Rights.

You have the following rights regarding Health Information we have about you:

Right to Inspect and Obtain a Copy of Your Medical Records. You can ask to see or get an electronic copy of your medical record or other health information we have about you. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Correct Your Medical Records. You can ask us to correct health information about you that you think is incorrect or incomplete. We may also say "no" to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Account of Disclosures. You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable, cost-based fee if you ask for another accounting within the 12-month period. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Limit Information We Share. You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request, unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.

Right to a Paper Copy of This Notice. You have right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer. You may obtain a copy of this notice at our websites at https://www.swcva.com/

Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office by contacting our Privacy Officer at [480.XXX.XXXX]. The Secretary of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be in writing. You will not be penalized for filing a complaint.

PATIENT: _____ **DATE:** _____

Financial Policy

You are financially responsible for the medical services you receive at Cardiojost Inc., Southwest Cardiovascular Associates (hereafter referred to as the "Practice"). Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

Appointments

1. **Copayments and Deductibles**. Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.

2. **Procedure Prepayment**. The Practice may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is based on an **estimate** of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

4. **Missed Appointments and Late Arrivals**. You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. **Initial:** _____

Insurance Payments

5. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

6. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial: _____

Benefits and Authorization

7. **Insurance Plan Participation.** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

8. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health

care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, the Practice is not required to agree with you.

As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.

9. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

10. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately. **Initial:**_____

Account Balances and Payments

11. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.**

12. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

13. **Returned Checks.** You will be charged for returned checks according to the Public Fee Schedule.

14. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Southwest Cardiovascular Associates 140 South Power Rd. Mesa, AZ. 85206.

15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt. **Initial:**_____

Additional Fees

16. **Medication Refill Requests.** All medication refill requests are to be approved by your provider. A fee will be charged according to the Public Fee Schedule for any of the following requests: lost prescriptions; urgent refill/office visit requests (same or next business day); and refills processed

after a missed appointment.

17. **Medical Records Requests.** The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into one of the Practice's clinics, the Practice will make every accommodation to fulfill your request. A fee will be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider

18. **Other Forms.** The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the Practice manager. All requests require an office visit. **Initial:**_____

19. **Acknowledgment of Notice of Privacy Practice.** By initialing this section, I acknowledge that I have received and reviewed a copy of the Practice's Notice of Privacy Practice. **Initial:**_____

20. **Public Fee Schedule.** By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **Initial:**_____

Practice Code of Conduct

We are pleased to serve you and glad that you chose SWCVA as your provider. We will always strive to provide exceptional care for you.

Reasons that SWCVA may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing. **Initial:**_____

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Southwest Cardiovascular Associates, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed:_____ Date: _____

A. Notifier: SOUTHWEST CARDIOLOGY ASSOCIATES

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your Insurance doesn't pay for **D.** the **Test(s)** below, you may have to pay.

Your Insurance Carrier does not pay for everything, even some care that you or your health care provider have

good reason to think you need. We expect your insurance may not pay for the **D. Test(s)**

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. ANS	Medical Necessity	$255.00
2. ABI	Medical Necessity	$91.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Test(s)** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice or insurance billing, call **the number listed on the back of your insurance card.** Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: