



Southwest

CardioVascular Associates

How Did You Find Us? _____

PATIENT NAME: _____
First Middle Last

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

SECONDARY ADDRESS: _____
Street Address City State Zip

HOME PHONE: _____ **CELL:** _____

***E-MAIL:** _____ **PATIENT PORTAL ACCESS:** Yes No (Circle One)

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

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

EMERGENCY CONTACT PHONE: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

(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
Month Day Year Child Life Partner Other _____

▼ **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.

SOCA-PKNEWPAT-SWCVA

†

PATIENT SIGNATURE

DATE



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

CARDIOVASCULAR

High Blood Pressure	Yes	No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fluttering Feeling in Chest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skipped Heartbeats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling in Ankles/Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CONSTITUTIONAL

Significant Weight Loss	Yes	No
Significant Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ENDOCRINE

Thyroid Problem	Yes	No
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EAR/NOSE/MOUTH/THROAT

Difficulty Swallowing	Yes	No
Dry, Hoarse Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No

EYES

Blurred/Double Vision	Yes	No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GASTROINTESTINAL

Indigestion/Nausea	Yes	No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GENITOURINARY

Loss of Bladder Control	Yes	No
Blood in Urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGY/LYMPHATIC

Breast Masses/Lumps	Yes	No
Enlarged Lymph Nodes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No

INTEGUMENTARY

Skin Rash	Yes	No
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MUSCULOSKELETAL

Arthritis	Yes	No
Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NEUROLOGICAL

Headaches/Migraines	Yes	No
Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness/Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PSYCHOLOGICAL

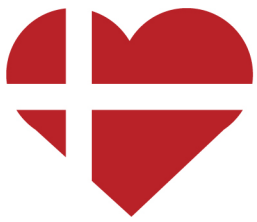
Depression	Yes	No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High/Unusual Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No

RESPIRATORY

Asthma	Yes	No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Valley Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NAME

DATE



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PATIENT MEDICAL HISTORY

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

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renal/Kidney Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intestinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anesthesia Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Valley Fever/TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Type of Cancer: _____		

SURGICAL PROCEDURES & OPERATIONS

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

<u>TYPE OF PROCEDURE</u>	<u>DATE</u>	<u>TYPE OF PROCEDURE</u>	<u>DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT FAMILY HISTORY

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

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Renal/Kidney Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		

Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Valley Fever/TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Who? _____		
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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



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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

May we phone, email, or send a text to you to confirm appointments?

YES NO

May we leave a message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with any member of your family?

YES NO

If YES, please list the name of the family members allowed:

Patient (Printed Name) or Responsible Party (Printed Name)

Patient Signature or Responsible Party

Date

Printed Name-Practice Representative

Title

Signature

Date



The Epworth Sleepiness Scale

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you have have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	●
Watching TV	●
Sitting inactive in a public place (e.g., a theater or a meeting)	●
As a passenger in a car for an hour without a break	●
Lying down to rest in the afternoon when circumstances permit	●
Sitting and talking to someone	●
Sitting quietly after a lunch without alcohol	●
In a car, while stopped for a few minutes in traffic	●

Total Score = _____

Have you ever been diagnosed with any of the following conditions (select all that apply)?:

- High Blood Pressure (uncontrolled)
- Heart Failure
- Artrial Fibrillation
- Stroke
- None of the above

Do you feel easily fatigued or lack stamina? Yes No

Have you ever received an overnight sleep study? Yes No

If Yes, has a physician ever diagnosed you with Central Sleep Apnea CSA or Obstructive Sleep Apnea OSA?

Type: _____ When: _____ Therapy Prescribed: _____ Compliant: Yes No

Patient Name: _____ DOB: _____ Signature: _____

Phone Number: _____



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Other Name Used: _____ Social Security #: _____

I request and authorize _____

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Other:

Patient Signature: _____ Date Signed: _____

WE REQUIRE AN UPDATED AUTHORIZATION EVERY 90 DAYS



Southwest
CardioVascular Associates

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.

Southwest Cardiovascular Associates are 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 of 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 details of your treatment, sharing our 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 hour's 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 strict 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 our 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 Communication:** 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 of 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 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.



Southwest Cardiovascular Associates

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 policies.

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Southwest Cardiovascular Associates of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments directly to SWCVA. Any payments sent directly to the patient should be forwarded to SWCVA with the Explanation of Benefits to prevent your account being subject to collections procedure and legal action. Authorization must be signed at the initial visit, upon any changes in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that SWCVA is a participating provider with your insurance company. All referrals to SWCVA are to be obtained prior to your appointment. This will prevent your appointment from needing to be rescheduled.

PAYMENT POLICY

Insured

All co-pays, deductibles and co-insurance must be paid before services are rendered. If unable to pay your amount due at the time of service, your appointment may be rescheduled.

Non-Insured

SWCVA requires full payment at the time of service unless prior arrangements have been made with our Billing Office.

Balances Due

Patient balances remaining after insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

Medical Forms

SWCVA requires full payment of \$30.00 at the time of your Insurance forms (FMLA, FAA Clearance, Disability, ect.) are dropped off for completion. Completion of forms is not paid by your insurance company.

24 hour Cancellation for Appointments

SWCVA requires a 24 hour advance notice for all appointment cancellations. 24 hour advanced notice is defined as 1 full business day, Monday through Friday. Varying fees will be charged to your account depending on the type of appointment. This charge is not covered by your insurance and is the patient's responsibility.

Non-Sufficient Funds/Return Checks

SWCVA will pass along to the patient a \$40.00 NSF bank charge for all returned checks. This fee will be added to your account and is the patient responsibility. The financial institution may charge additional fees to you directly.

FINANCIAL POLICY ACKNOWLEDGEMENT

(Mandatory for All Patients)

†By signing my name below, I acknowledge that I have read and understand the updated Financial Policy of CardioJost, Inc. (Southwest Cardiovascular Associates) as well as the cover letter attached. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check, MasterCard, Discover or Visa. I agree that if my account is referred to a collection agency or attorney I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

(Mandatory for All Patients)

†By signing my name below, I authorize the release of medical information necessary for filing health insurance claims for me by CardioJost, Inc. (dba: Southwest Cardiovascular Associates). I also authorize my insurance carriers to make payments directly to these companies.

PATIENT NAME

PATIENT SIGNATURE

DATE