Welcome to Heart and Health Medical

PLEASE REVIEW THE INFORMATION AND FILL ANY MISSING INFORMATION

Date:

PATIENT INFORMATION:			
First Name:		**Last Name:**	
SSN:	**DOB:**	**Age:**	**Gender:**
Address:			
Home contact number:			
Cell phone contact number:			
Work contact number:			
E-mail address:			

Occupation: _____

Please indicate how you were referred to us: _____

INSURANCE INFORMATION (PLEASE REVIEW CAREFULLY)

Subscriber's Name: _____
Subscriber's DOB: _____
Primary Insurance: _____
Insurance ID: _____
Group Number: _____
Address: _____
Contact Number: _____
Patients relationship to subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child**

SECONDARY INSURANCE (If Applicable)

Subscriber's Name: _____
Secondary Insurance: _____
Secondary Insurance ID: _____
Secondary Group Number: _____
Patients relationship to subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child**

****INCASE OF AN EMERGENCY****		
Name	**Relationship:**	**Best Contact Numbers:**

****To whom can we disclose your medical information ?****

Name	**Relationship:**	**Best Contact Numbers:**

Consent for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Heart and Health Medical and all its medical providers for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Heart and Health Medical I understand that diagnosis or treatment of me by any medical provider may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Heart and Health Medical is not required to agree to the restrictions that I may request. However, if Heart and Health Medical agrees to a restriction that I request, the restriction is binding on Heart and Health Medical. I have the right to revoke this consent, in writing, at any time, except to the extent that Heart and Health Medical has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand

I have a right to review Heart and Health Medical Notice of Privacy Practices prior to signing this document. The Heart and Health Medical Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Heart and Health Medical. This Notice of Privacy Practices also describes my rights and Heart and Health Medical duties with respect to my protected health information. Heart and Health Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Heart and Health Medical and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature:	**(Signature of Staff Member):**

Financial Policy and Agreement

1. Payments of Services: Payment of services is expected at the time or before services are rendered. Before any services are performed, you may ask to be informed of the cost associated so that you may decide whether or not to seek treatment at our facility. You may pay by cash, major credit cards, or check with a valid NYS license. All deductibles have to paid before any medical services provided.

2. Insurance: This office accepts a full range of insurance plans to offer flexibility to our patients. Your Insurance policy is a contract between you and your insurance carrier. Read it, understand it, and ask questions. It is the patient's responsibility to know what your policy covers and what it does not. Please understand that some policies from the same insurance company can have different requirements. We do expect our patients to present their insurance identification cards or enrollment forms at the time of service. Without this information we may have to reschedule your appointment or you may have to pay at the time of service. Some plans require a referral or prior approval from your primary care provider. It is your responsibility to obtain this referral. If you do not have this referral or prior authorization, you will be responsible for payment or we will reschedule your appointment. All co-pays and co-insurance associated with your managed care plan must be paid at the time of service using the options in the first section of this policy.

3. Payment Plan: Special needs are understood by this office. In cases of financial hardship, it may be necessary to set up a payment plan. If this situation is necessary for you, please bring this to our attention as soon as possible.

4. Fees: I am aware that I am personally responsible to pay all services rendered that are not covered or have limited coverage within my policy. I am also aware that in the event that my account should become past due more than 90 days, collection procedures will be implemented by Heart and Health Medical. I will be responsible for all the legal fees, collection agency fees and any other expenses involved in the collection process. A photostatic copy of this authorization will be as valid as the original.

-Bounced Check Fee $30: In the event of a bounced check, this fee will be applied to my account.
-No Show/Cancellations $30:All NO SHOW or cancellation less than 24 hours before an appointment.
-Missed Co-Payments $20. Co-payments not paid at the time of visit, will be subject to this fee.
-Medical Records: Copies of Medical records are subject to a 0.75 cents per page fee and a $15 mailing,and processing fee.
-Special Forms - $10 per page Special forms/documents are subject to fee, other types of forms may require additional charges.

5. Insurance Denials or Non-payment: In the event that any medical service is denied by your insurance carrier for ineligibility, no referral, not medically necessary, investigational or any other reason, the remaining balance will become your responsibility. If a claim is sixty (60) days old and there has been no response from the insurance carrier, the balance due will be turned over to you. Over due accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. Please contact our Billing Department if you have any questions or concerns.

6. Medical information Disclosure Policy: Due to the HIPAA Privacy rules, OUR OFFICE POLICY is that we will not share or provide any medical information such as X-ray, Lab results, test results, diagnosis, prognosis, or treatment plans over the telephone. It is your responsibility to make a follow up appointment to discuss these results with your medical provider. Not receiving a phone call from our office does not indicate a NORMAL result.

I, _____ , have been given, reviewed and accepted the following guidelines and rules:

1-Patient's Bill of Right
2- Notice Of Privacy Practices.
3- HIPPA Joint Privacy Rule-Effective Sept. 23, 2013
4- Heart and Health Medical Financial agreement, Patient Record Disclosure, Controlled Substance Agreement, and Office Policy.

By signing this form, I agree and accept all Heart and Health Medical rules and regulations. All my questions have been answered to my full satisfaction. I understand that I am financially responsible for any unpaid balance. I understand that I may revoke this authorization at any time by notifying Heart and Health Medical, in writing. If I do revoke authorization, it will not have any effect on any actions taken by Heart and Health Medical, prior to the receipt of the revocation. I understand that all the above guidelines and rules would be provided to me in writing upon my request.

Signature:	**(Signature of Staff Member):**

HEALTH HISTORY QUESTIONNAIRE

Name	Gender:	DOB:
Reason for Today's Visit:		
Previous or referring doctor:	Date of last physical exam:	

☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Stroke/Mini stroke/TIA
☐ Rheumatic Fever ☐ Obesity ☐ Congestive Heart Failure ☐ Arrhythmia
☐ Liver Disease ☐ Metabolic Syndrome ☐ Kidney Disease ☐ Murmur
☐ Leg Pain with Walking ☐ Palpitations ☐ Ulcer/Reflux ☐ Dizziness/Fainting
☐ Other _____ ☐ Other _____

Smoke Y N	Packs Daily:	# of Years
Exercise Y N	Type:	# of Days Per Week
Alcohol Y N	Type:	Amount:

List any medical problems that other doctors have diagnosed: _____

SURGERIES

Year:	Reason:	Year:	Reason:
Year:	Reason:	Year:	Reason:

FAMILY HISTORY

Father	☐ Heart Attack Angioplasty ☐ Stent/ Bypass Surgery ☐ High Cholesterol ☐ Obesity ☐ Metabolic Syndrome	Age:
Mother	☐ Heart Attack Angioplasty ☐ Stent/ Bypass Surgery ☐ High Cholesterol ☐ Obesity ☐ Metabolic Syndrome	Age:
Sister	☐ Heart Attack Angioplasty ☐ Stent/ Bypass Surgery ☐ High Cholesterol ☐ Obesity ☐ Metabolic Syndrome	Age:
Brother	☐ Heart Attack Angioplasty ☐ Stent/ Bypass Surgery ☐ High Cholesterol ☐ Obesity ☐ Metabolic Syndrome	Age:

Other: _____

MEDICATIONS *(List your prescribed drugs and over-the-counter drugs, such as vitamins and inhaler)*

Name	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name of the Drug	Reaction You Had