# Advanced Heart Care Center
## Patient Registration Form

Last Name: ______________________________ First Name: _________________________ MI: _______

Gender: ◻ Male ◻ Female Date of Birth: __________________ Social Security: ____________________

Mailing Address: __________________________________________________ Apt #: _________________

City: ____________________________________ State: _______________ Zip: _____________________

Home Phone: ________________ Cell Phone: ____________________ Work Phone: __________________

Race:
- ◻ Asian
- ◻ Black or African American
- ◻ White
- ◻ Other Race
- ◻ Decline to specify

Ethnicity:
- ◻ Hispanic or Latino
- ◻ Not Hispanic or Latino
- ◻ Decline to specify

Marital Status:
- ◻ Single
- ◻ Married
- ◻ Divorced
- ◻ Legally Separated
- ◻ Partner
- ◻ Widowed
- ◻ Decline to specify

Email Address: ______________________________________________________

Emergency Contact Person: ______________________ Relationship: __________ Phone: _______________

Primary Care Physician: _________________________ Referring Physician: ___________________________

Employer's Name: __________________________________ Occupation: ___________________________

Employer's Mailing Address: __________________________________________________________________

City: ____________________________________ State: ________ Zip: ______________

## Insurance

Insurance card(s) or proof of insurance must be presented at time of service

**Primary Insurance:** ______________________________ Policy Number: _________________________

Policy Holder's Name: ______________________________ Policy Holder's Date of Birth: ________________

**Secondary Insurance:** _____________________________ Policy Number: _________________________

Policy Holder's Name: ______________________________ Policy Holder's Date of Birth: ________________

### Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Advanced Heart Care Center. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

______________________________________________ ____________________________________

**Signature of Patient or Personal Representative** **Date**

==========================================================================================

### Financial Acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

______________________________________________ ____________________________________

**Signature of Patient or Personal Representative** **Date**

# ADVANCED HEART CARE CENTER
# MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ________________________________ Appointment Date: __________________

Date of Birth: ______________________ Gender: ☐ Male ☐ Female

Primary Care Doctor: ______________________________ Office Phone: ______________________

Pharmacy Name/Location/Phone: _______________________________________________________

**REASON FOR VISIT:** ☐ Routine follow up ☐ Hospital follow up
☐ Surgery clearance ☐ Other ______________________________

☐ YES ☐ NO Do you have a living will or a medical power of attorney?

☐ YES ☐ NO Have you had this season's flu vaccine?

☐ YES ☐ NO Have you had your pneumonia vaccine?

☐ YES ☐ NO Have you had your COVID-19 vaccine(s)?

**ALLERGIES:**

☐ YES ☐ NO Have you had a reaction to x-ray contrast dye?

☐ YES ☐ NO Are you allergic to iodine or shellfish?

☐ YES ☐ NO Are you allergic to any adhesives?

☐ YES ☐ NO Are you allergic to any medications? If yes: ________________________________

**PAST MEDICAL HISTORY:** (Please indicate if you have been diagnosed with any of the following)

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Carotid disease | ☐ Cardiomyopathy | ☐ Heart failure |
| ☐ Anemia | ☐ HIV/AIDS | ☐ Syncope (passing out) | ☐ Angina (chest pain) |
| ☐ Asthma | ☐ Liver problems | ☐ Coronary artery disease | ☐ Heart arrhythmia |
| ☐ Diabetes | ☐ Kidney disease | ☐ High cholesterol | ☐ Heart attack |
| ☐ COPD | ☐ Sleep apnea | ☐ High blood pressure | ☐ Heart murmur |
| ☐ Emphysema | ☐ Depression | ☐ Atrial fibrillation (afib) | ☐ Aneurysm |
| ☐ Anxiety | ☐ Thyroid disorder | ☐ Cancer _______________ | ☐ _____________ |
| ☐ TIA/Stroke | ☐ Clotting disorder | ☐ Hepatitis [ ☐ A ☐ B ☐ C ] | ☐ _____________ |
| ☐ Peripheral arterial disease (PAD) | | ☐ Blood clots in veins or lungs | |

## PAST SURGICAL HISTORY:

☐ AAA repair ☐ Carotid stenting ☐ Peripheral stenting ☐ Coronary stenting
☐ Cardiac ablation ☐ ASD or VSD repair ☐ Valve repair/replacement ☐ ICD (defibrillator)
☐ Coronary bypass ☐ Heart transplant ☐ Cardioversion ☐ Pacemaker
☐ Hysterectomy ☐ Gallbladder removal ☐ C-section ☐ Tonsillectomy
☐ Vasectomy ☐ Carpal tunnel release ☐ Cataract surgery ☐ Knee surgery
☐ LVAD implant ☐ Appendectomy ☐ Hip surgery ☐ Hernia repair
☐ ____________________ ☐ ____________________ ☐ ____________________ ☐ _______________

## FAMILY HISTORY: ☐ Adopted ☐ Family History Unknown

| Relationship | Alive or Deceased? | Atrial fibrillation | Coronary artery disease | Clotting disorder | Diabetes | Heart attack | Heart disease | Heart failure | High cholesterol | High blood pressure | Stroke | Other: ____ | Other: ____ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | |
| Paternal grandmother | | | | | | | | | | | | | |
| Paternal grandfather | | | | | | | | | | | | | |
| Maternal grandmother | | | | | | | | | | | | | |
| Maternal grandfather | | | | | | | | | | | | | |

## YOUR SOCIAL HISTORY AND HABITS:

**Alcohol Use:** ☐ YES ☐ NO If yes, how many drinks per day? ____________________

**Drug Use:** ☐ YES ☐ NO Have you ever used intravenous drugs or cocaine? ☐ YES ☐ NO

Have you ever used illegal drugs or addicted to prescription pain medications? ☐ YES ☐ NO

**Tobacco Use:** ☐ Never smoker ☐ Current smoker (If current, ____ packs per day for _____ years).

☐ Former smoker If former, quit date? __________

Do you have second-hand smoke exposure? ☐ YES ☐ NO

Currently use smokeless tobacco: ☐ Chew ☐ Snuff ☐ E-Cig/Vape
If previous tobacco user, _____ years. Quit date? __________

**Exercise:** Do you exercise regularly? ☐ YES ☐ NO
**Caffeine Use:** How many caffeinated beverages to you drink per day (coffee, soft drinks, tea)? _________

# Advanced Heart Care Center

## PATIENT CONSENT FORM

### General Consent for Care and Treatment

*TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request an Advanced Heart Care Center physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Advanced Heart Care Center. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

________________________________________ ____________________
Signature of Patient or Personal Representative — Date

________________________________________ ____________________
Printed Name of Patient or Personal Representative — Relationship to Patient

________________________________________ ____________________
Signature of Witnessing Employee — Date

________________________________________ ____________________
Printed Name Witnessing Employee — Employee Job Title

# ADVANCED HEART CARE CENTER
# Patient HIPAA Acknowledgment and Consent Form

| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| | | | |

**Notice of Privacy Practice/Clinics:**

_______ ***(Patient/Representative Initials)*** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which Advanced Heart Care Center may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

**Disclosures to Friends and/or Family Members:**

Do you want to designate a family member or other individual with whom the provided may discuss your medical condition? If yes, to whom?
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family member(s) and others listed below:

| | Name | Relationship | Contact Number |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Communication About My Healthcare:**

I agree Advanced Heart Care Center may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

**Consent for Photographing or Other Recording for Security and/or Health Care Operations:**

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or for Advanced Heart Care Center's health care operations purposes (e.g., quality improvement activities). I understand that Advanced Heart Care Center retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:**

If at any time I provide an email address or cell phone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to the following: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communication may include, but are not limited to, communication to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. Advanced Heart Care Center does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Note:** This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all of our affiliated locations that share an electronic health record in which you have a relationship.

# ADVANCED HEART CARE CENTER
# Patient HIPAA Acknowledgment and Consent Form

| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| | | | |

**Release of Information:**
I hereby permit Advanced Heart Care Center and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**Prescription Order Pick-up:**
There may be times when you need a friend or family member to pick up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we
will need to have a record of their name. Prior to release of the prescription, your designee will need to present a valid picture identification and sign for the prescription.

- _______ ***(Patient/Representative Initials)*** **I do want** to designate the following individual(s) to pick up a prescription order on my behalf:

| Name | Relationship to Patient (self, parent, legal guardian/representative, etc.) | Date |
|---|---|---|
| | | |
| | | |

- _______ ***(Patient/Representative Initials)*** **I do not want** to designate anyone to pick up my prescription order

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**I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.**

| Patient/Representative Signature | Relationship to Patient (self, parent, legal guardian/representative, etc) | Date |
|---|---|---|
| | | |

Updated: April 7, 2022
A photocopy of this consent shall be considered as valid as the original.