PATIENT REGISTRATION

First Name:____ MI:____ Last Name:___________________________________

Email Address:_____________________________________ Date of Birth:___/___/___ Sex: M F

Address:____ Apt:______ City:_______________ State:____ Zip:_______

Home Phone:________________ Cell Phone:__________________ Work Phone:________________________

Marital Status: S D M W Student: Not Full Time Part Time

Employer:____

Primary Care Doctor:____ Phone:__________________________

Pharmacy:_______________________________________ Cross Streets:________________________&____________________

Mail Delivery Pharmacy:____________________________________ Contact Number:(_____)____________________

INSURANCE INFORMATION

Primary Insurance:____________________________________ Phone:(_____)________________________

Policy Number:____________________________________ Group Number:________________________

Policy Holder:________________________________ Relationship:___________________________

Claims Address:____ City:___________________State:_____ Zip:_________

Secondary Insurance:___________________________________ Phone:(_____)________________________

Policy Number:______________________________________ Group Number:________________________

Policy Holder:________________________________ Relationship:___________________________

Claims Address:____ City:_________________ State:_____ Zip:_________

I hereby give permission to Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP to treat me as necessary. I understand my insurance company may assist me in paying all medical costs, but 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 incurrent due to any delinquent accounts I may have. I further more authorize payment of medical benefits directly to my physician for services rendered.

<u>Release of Private Health Care Information</u>

I hereby give permission for the following person(s) to contact the office on my behalf to discuss my private healthcare information with the providers/staff or billing personnel of Gilbert Cardiology:

Name:____________________________________ Relation:___________________________ Phone:(_____)_____________

Name:____________________________________ Relation:___________________________ Phone:(_____)_____________

<u>EMERGENCY CONTACT INFORMATION:</u>

Name:____________________________________ Relation:___________________________ Phone:(_____)_____________

Name:____________________________________ Relation:___________________________ Phone:(_____)_____________

- Patient Signature:____ Date:______/______/______

Gilbert Cardiology

Financial Policy and Patient Responsibility

Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-workers. If you are not familiar with you plan coverage. We recommend you contact your carrier directly.
- To obtain a referral from their primary care physician and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay at the time of arrival.
- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month (or 18% per year) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- A 60 day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgemets:

I have read and understood the above financial policy. 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, MasterCard 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.

➢ ______________________________ ______________________________ ____________

Printed Patient Name Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claim forms for me by Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP. I also authorize my insurance carriers to make payments directly to these companies.

➢ ______________________________ ____________

Signature Date

Authorization for Medical Records Request/ Release

- Patient Name:___________________________
- Date of Birth: _____/_____/_______

You are hereby authorized to release/request any medical notes, reports, labs, operative reports and films to/from Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP.

(FOR OFFICE TO FILL OUT)
We specifically
request:____
____
____

I hereby release Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP and its staff from liability and all claims of nature whatsoever, pertaining to disclosure of this information.

If I have requested these records for my own personal use, I am responsible for the safe keeping of these records. Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP and its staff is not responsible if these records were to get damaged or last once given to me.

- ____
  Patient Signature/Personal Representative Signature

(FOR OFFICE TO FILL OUT)
Dr. Name:______________________________________
Phone Number:__________________________________
Fax Number:____________________________________

Appointment Cancellation Policy

If you do not cancel your appointment that is scheduled with either Dr. Zaki Lababidi, Dr. Mohammad Hojjati, or Dr. Khaled Albasha **24 hours** prior to your appointment time, you will incur a $**50** charge.

If you do need to cancel an appointment, the staff at Gilbert Cardiology will be more than happy to accommodate you.

I have read and understood the policy at Gilbert Cardiology regarding cancelled appointments.

- Printed Name:___________________________________
- Signature:_______________________________________
- Date: _____/_____/_______

Your Health Information Rights:

Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy:

You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit your request in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information complied in reasonable anticipation of, or for us in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conduction the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Gilbert Cardiology in writing. The practice reserves the right to charge for copying of records per the state regulations.

Amend:

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial,

An accounting of Disclosures:

You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Gilbert Cardiology will provide the first accounting to you in any 12-month period without charge, upon your written request. The cost for subsequent requests for an accounting within the 12-month period will be $10.00

Request Restrictions:

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not disclose information about a procedure that you had. We ask that you submit these requests in writing. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communication:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice:

You have the right to a paper copy of this notice. You ay ask us to give you a copy of this notice at any time. Even if you have agree to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us by calling (480) 786-9100 and asking for the Privacy Officer or by contacting the secretary of the Federal Department of Health and Human Services by calling 1-800-368-1019, or by contracting the Office of Civil Rights regional office. All complaints must be also submitted in writing within 180 days of when you knew that the act or omission complained of occurred. You will not be penalized for filing a complaint.

Other Uses or Medical Information:

Other uses and disclosures of medical information not covered by this Notice of the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke that permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosure we have already made with your permission and we are required to retain our of the care that we provided to you.

Privacy Officer: Chief Financial Officer. Telephone Number: (480) 786-9100.

This information is advisory only. Final interpretation is the responsibility of the regulatory or accrediting body administering the standard or regulation referenced.

Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003

3505 S. Mercy Rd
Gilbert, AZ 85297

Phone: (480) 786-9100
Fax: (480) 786-0742

PATIENT HISTORY

Date:___________________________________

First Name_________________________ **Middle Name**__________ **Last Name**_____________________
Occupation:_________________________ **Retired: Y or N**
Marital Status:_______________________
Referring Doctor:___________________________________
Reason for Visit: What cardiac or vascular problems do you have?

PERSONAL HISTORY AND RISK FACTOR

Have you ever experienced or have been diagnosed with:

Condition			
Congestive Heart failure	Yes	No	When? ____________________________
Heart Attack (myocardial infarction)	Yes	No	When? ____________________________
High Blood Pressure	Yes	No	When? ____________________________
Diabetes	Yes	No	When? ____________________________
Stroke	Yes	No	When? ____________________________
High Cholesterol	Yes	No	When? ____________________________
Cancer	Yes	No	When? ____________________________
Lung Disease	Yes	No	When? ____________________________
Kidney Problems	Yes	No	When? ____________________________
Bleeding Tendencies	Yes	No	When? ____________________________
Thyroid Disorder	Yes	No	When? ____________________________
Peripheral Vascular Disease	Yes	No	When? ____________________________
Heart Valve Disease	Yes	No	When? ____________________________
Other Major Illness_______________________________			When? ____________________________

SURGERIES:

Heart Surgery Yes No When?____________________________
What Procedures?____

Vascular Surgery Yes No When?____________________________
What Procedures?____

Cardiovascular Procedures/Intervention Yes No When? ______________________
What Procedures?____

OTHER SURGERIES:

Type:____ When?______________________________
Type:____ When?______________________________
Type:____ When?______________________________
Type:____ When?______________________________

FEMALES ONLY:

Have you had a total Hysterectomy (ovaries and uterus removed)? Yes No Age____________
Do You take Birth Control Pills? Yes No
Have you gone through Menopause? Yes No
Are You taking hormone replacements? Yes No

HABITS

DO YOU:

Use Tobacco Yes No How Much?__________________
When did you quit?_________________________

Drink Alcohol Yes No How Much?__________________
How Long?____________ When did you quit_____________

Drink Caffeine Yes No How Much?__________________
When did you quit?_______________________________________

Take Illicit Drugs Yes No How Much?__________________
How Long?__________ When Did you quit?____________

List any problems with mobility or self care:_

____
____
____
____

____

FAMILY HISTORY

Mother: Alive_____ Age_____ Deceased______ age Deceased________
Major Health problems**:**____

Father: Alive______Age______ Deceased_______ age Deceased________
Major Health problems____

Brothers: Alive______Ages:______ Deceased________ age Deceased________
Major Health problems____

Sisters: Alive______Ages:______ Deceased________age Deceased________
Major Health problems____

Children: Alive______Ages:_______ Deceased_________age Deceased________
Major Health problems____

Has any blood relative died suddenly? Yes____ No__Age______ Relation________________

Allergies or intolerance to medications? Yes_____No____
Medication/Reaction:____

Other Allergies (foods, adhesive tape, X-ray contrast dye, latex, etc). Yes_________ No________
What/Reaaction:____

CURRENT MEDICATIONS

Drug	Dosage (mg)	How Many times per day?

PATIENT HEALTH CHECKLIST

Check only the problems you frequently experience or have been treated for in the past:

Constitutional
______Significant weight change
______Night Sweats
______Unexplained Fever

Eyes
______Cataracts
______Blurred or double vision
______Glaucoma

ENMT
______Difficult swallowing
______Dry, hoarse throat

Cardiovascular
______Chest discomfort
______Fluttering feeling in chest
______Skipped Heartbeats
______Swelling in ankles/feet

Respiratory
______Wheezing
______Chronic cough
______Asthma
______History of Tuberculosis
______Shortness of breath

Gastrointestinal
______Indigestion
______Ulcers

Genitourinary
______Loss of bladder control
______Blood in urine

Musculoskeletal
______Arthritis
______Back Pain
______Muscle weakness

Integumentary
______Skin Rash

Neurological
_______Headache
_______Memory Loss
_______Stroke
_______Speech problems

Psychological
_______Depression
_______Anxiety
_______Unusual stress
_______Eating disorder

Endocrine
_______Thyroid problems

Hematology/Lymphatic
Breast masses/lumps
Unexplained bruising

Allergic/Immunologic
______Drug allergies
______Mold, pollen, dust allergies

Other:___________________________

Comments:

Physician Signature:___________________________________ Date:_______________________

Acknowledgement of Privacy Practices

Notice of Acknowledgement of Privacy Practices:

I acknowledge that I have received, been offered, or reviewed Gilbert Cardiology's Notice of Privacy Practices.

- Patient Signature:______________________________ Date:________________

OR

- Personal Representative Signature:__________________________ Relation:______________________ Date:________________

If you would like any person(s) to be able to communicate with Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP or office staff about your care, please include their name below. You many add or remove any person at any time.

You may discuss my care with the following person(s):

____	____
Name	**Name**
____	____
Name	**Name**

Insurance Information/Policy/Responsibility

As a patient, you are responsible for knowing your insurance policy and verifying participation. For example, you will be responsible for any charges if any of the following apply:

- Your health plan requires prior authorizations or referral by a primary care physician (PCP) before receiving services at **Gilbert Cardiology**, and you have not obtained such an authorization or referral.
- You receive services in excess of such authorization or referral.
- Your health plan determines that the services you received at **Gilbert Cardiology** are not medically necessary and /or not covered by your insurance plan.
- Your health plan coverage has lapsed or expired at the time you receive services at **Gilbert Cardiology**.
- You have chosen not to use your health plan coverage. If you are not familiar with your insurance plan coverage, we recommend you contact your carrier or plan facility.

Gilbert Cardiology will attempt to obtain referrals from the patients primary care physician (PCP) if one is required, however it is patient responsibility to make sure that referral is obtained. **Gilbert Cardiology** will also try to obtain prior authorizations for any testing that is performed in the office through the patient's insurance company. **Gilbert Cardiology** will inform the patient if the testing is *DENIED* by insurance *PRIOR* to the patient's scheduled appointment. However, it is up to the patient to determine any out of pocket cost and/or expenses for the particular testing.

Patient Name (print):____

Patinet Name (signature):____

Date:________________________

Advanced Beneficiary Notice (ABN)

- Patient's Name: ____________________________________
- Medicare Number: _________-_______-________________
- Authorization Period: From: _____/_____/_______ To: _____/_____/_______
  (***Or until rescinded)

"I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I also authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim of any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

- Patient's Signature:___________________________________
- Date: _____/_____/_______