Comprehensive Cardiac Care, pllc

Helen S. Barold, MD, MPH, FACC, FHRS

Patient Information Form

Name:_____ Marital Status: S/M/D/W/P
First Middle Last

Address:_____
City State Zip

Home Phone:_____ Cell Phone:_____ Work Phone:_____

May we leave a message? _____ If so, on which phone number? ☐Home ☐Cell ☐Work

Soc Sec #:_____ Birthdate:_____ Age:_____ Sex:_____

Race: _____ Ethnicity: _____ Preferred Language: _____

Email Address:_____

Primary Care Physician:_____ Phone:_____

Pharmacy Information:(Name)_____ Phone:_____

Pharmacy Address:_____

Insurance Name: _____ Subscriber ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Whom May We Contact In Case Of An Emergency? _____

Whom May We Thank For Referring You To Us? _____

_____

Guarantor information, please fill out the following information if someone other than the patient is responsible for the bill.

Name:_____ Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer/Name/Address:_____

Relationship to patient_____

_____

I authorize Comprehensive Cardiac Care to apply for benefits on my behalf from my insurance carrier and request payment for covered services to be made directly to Comprehensive Cardiac Care. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Sign_____ Date_____

Comprehensive Cardiac Care, pllc

Welcome To Our Practice

Insurance Cards: Must be shown at each visit. Please bring your insurance card to every visit.

Copays: Copays will be paid at each visit.

Insurance Participation: A single insurance company may have many different plans. We may not participate in your particular plan. It is your responsibility to determine whether the doctor participates with your plan. We also ask that you become knowledgeable of the services that are not covered under your particular plan. If you have any questions concerning non covered services please call your benefits administrator. We will do our best to assist you with this.

Managed Care Referrals: If you are a member of an HMO or a managed care plan you must have a referral from your primary care physician prior to your visit. Comprehensive Cardiac Care will not be able to request a referral on your behalf. Patients should assume the responsibility of knowing how many visits have been extended for cardiology services and when your referral expires.

Patient Statements: You will be kept informed of what is happening with your insurance claim by means of and "EOB" (explanation of benefits) which is sent to you by your primary insurance carrier. Soon after we receive an EOB from your insurance and determine your out of pocket expense, we will send you a statement requesting payment. If you do not respond to the first request for payment, we will charge the credit card on file (if available). If not, we may send your account to our collection agency. Comprehensive Cardiac Care will not pay collections fees, all fees that are incurred by the collection agency will be your responsibility to pay.

CRISP: We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

My signature below acknowledges my understanding of all policies.

Signed_____ **Date**_____

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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 Carefully
Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medial record to all health care professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to day activities and management of Comprehensive Cardiac Care. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information. Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe interest you.

Individual Rights. You have certain rights under the federal privacy standards. These Include:
- The right to request restrictions on the use and disclosures of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Comprehensive Cardiac Care Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by change in federal, state laws and regulations. Upon request, we will provide you with the most recent revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Comprehensive Cardiac Care. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Effective Date. This notice is in effect on or after January 1, 2009

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Comprehensive Cardiac Care's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content and the notice, and I request the following restrictions(s) concerning the use of my person medical information:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ **Date:**_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:_____ **Witnessed by:**_____

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Name _____

List all your medications and dosages

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

List your drug allergies

_____ _____

_____ _____

List all your medical conditions (current and previous)

_____ _____

_____ _____

_____ _____

Check all that apply

1. Allergy
   - Ear Fullness ☐ Yes ☐ No
   - Itchy Eyes ☐ Yes ☐ No
   - Runny Nose ☐ Yes ☐ No
   - Scratchy Throat ☐ Yes ☐ No
   - Sinus Congestion ☐ Yes ☐ No
2. Respiratory
   - Chest Congestion ☐ Yes ☐ No
   - Cough ☐ Yes ☐ No
   - Shortness of Breath ☐ Yes ☐ No
3. Cardiovascular
   - Chest Discomfort/pain ☐ Yes ☐ No
   - Dizziness ☐ Yes ☐ No
   - Known Coronary Artery Disease ☐ Yes ☐ No
   - Heart Racing (Palpitations) ☐ Yes ☐ No
   - Shortness of Breath ☐ Yes ☐ No
   - Fainting Spells ☐ Yes ☐ No
   - Swelling in Legs ☐ Yes ☐ No

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Name _____

4. General
   - Fatigue ☐ Yes ☐ No
   - Fevers ☐ Yes ☐ No
   - Headache ☐ Yes ☐ No
   - Loss of Appetite ☐ Yes ☐ No
   - Weakness ☐ Yes ☐ No
   - Weight Gain ☐ Yes ☐ No
   - Weight Loss ☐ Yes ☐ No
   - Do you exercise regularly? ☐ Yes ☐ No
   - Do you smoke? ☐ Yes ☐ No
   - Pregnancies ☐ Yes ☐ No
     - How many? _____

5. Vascular
   - Varicose veins ☐ Yes ☐ No
   - Phlebitis ☐ Yes ☐ No
   - Blood clots ☐ Yes ☐ No
   - Deep Vein Thrombosis ☐ Yes ☐ No

   Do you experience any of the following in your leg(s):
   - Aching/pain ☐ Yes ☐ No
   - Heaviness ☐ Yes ☐ No
   - Tiredness/fatigue ☐ Yes ☐ No
   - Swelling ☐ Yes ☐ No
   - Cramps ☐ Yes ☐ No
   - Restless legs ☐ Yes ☐ No
   - Throbbing ☐ Yes ☐ No
   - Skin or ulcer problems ☐ Yes ☐ No

6. Endocrine
   - No Problems ☐ Yes ☐ No
   - Diabetes ☐ Yes ☐ No
   - Thyroid Disease ☐ Yes ☐ No
   - Problems with Heat or Cold ☐ Yes ☐ No

7. Ears/Nose/Mouth/Throat
   - Cough ☐ Yes ☐ No
   - Nose Bleeds ☐ Yes ☐ No
   - Hearing Loss ☐ Yes ☐ No
   - Ringing in Ears ☐ Yes ☐ No
   - Sinus Pain ☐ Yes ☐ No
   - Sore Throat ☐ Yes ☐ No
   - Vomiting ☐ Yes ☐ No

8. Gastrointestinal
   - Abdominal Pain ☐ Yes ☐ No
   - Blood in Stool ☐ Yes ☐ No
   - Constipation ☐ Yes ☐ No
   - Diarrhea ☐ Yes ☐ No
   - Heartburn ☐ Yes ☐ No
   - Nausea ☐ Yes ☐ No

9. Hematology
   - Bleeding ☐ Yes ☐ No
   - Easy Bruising ☐ Yes ☐ No

10. Musculoskeletal
    - Joint Pain ☐ Yes ☐ No
    - Joint Stiffness ☐ Yes ☐ No
    - Joint Swelling ☐ Yes ☐ No
    - Leg Cramps ☐ Yes ☐ No
    - Muscle Aches ☐ Yes ☐ No
    - Osteoporosis Treatment ☐ Yes ☐ No
    - Sciatica ☐ Yes ☐ No

11. Neurological
    - Dizziness ☐ Yes ☐ No
    - Walking Problems ☐ Yes ☐ No
    - Headaches ☐ Yes ☐ No
    - Insomnia ☐ Yes ☐ No
    - Memory Loss ☐ Yes ☐ No
    - Seizures ☐ Yes ☐ No
    - History of a Stroke or Mini-Stroke (TIA) ☐ Yes ☐ No

12. Psychiatric
    - Anxiety ☐ Yes ☐ No
    - Depression ☐ Yes ☐ No
    - High Stress Level ☐ Yes ☐ No
    - Sleep Disturbances ☐ Yes ☐ No

13. Urology
    - Blood in the Urine ☐ Yes ☐ No
    - Difficulty Urinating ☐ Yes ☐ No
    - Frequent Urination ☐ Yes ☐ No
    - Frequent Urinary Tract Infections ☐ Yes ☐ No

14. Family History

    Have any of your family members had:
    - Blood coagulation disorder ☐ Yes ☐ No
    - Blood Clots ☐ Yes ☐ No
    - Stroke, heart attacks or Pulmonary emboli ☐ Yes ☐ No