PLEASE PRINT

CARDIOVASCULAR CONSULTANTS, P.C.
PATIENT INFORMATION

Please bring with you Picture ID, Insurance cards & Medication List

Patient Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____

Social Security # _____ Birth Date _____ Gender _____ Marital Status _____

Email Address _____ Preferred Notification Method - Postal Mail - Phone - Email (circle one)

Race White American Indian Asian (circle one) Black or African American Other

Ethnicity Hispanic or Latino (circle one) Not Hispanic or Latino

Language _____

Employer's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Family Doctor _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Phone # _____ Local or Mail Order _____

Address or Main Cross Roads _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____

GUARANTOR INFORMATION (if different than above)

Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Gender _____ Relationship _____

Primary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS# _____ Birthdate _____

Secondary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS # _____ Birthdate _____

AUTHORIZATION TO PAY BENEFITS: I HEREBY ATHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CARDIOVASCULAR CONSULTANTS, P.C., REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE CARDIOVASCULAR CONSULTANTS, P.C., TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____

Cardiovascular Consultants, P.C.

Diagnostic and Interventional Cardiology

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

RISK FACTORS **PHYSICIAN COMMENTS**

Diabetes	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes
High cholesterol	☐ No	☐ Yes
Smoking	☐ No	☐ Yes
Family history of heart disease	☐ No	☐ Yes
Are you overweight?	☐ No	☐ Yes
Are you involved in regular exercise program?	☐ No	☐ Yes

PAST MEDICAL HISTORY

Heart attack	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes
Heart failure	☐ No	☐ Yes
Hereditary heart defects	☐ No	☐ Yes
Blood clots in the lung	☐ No	☐ Yes
Blood clots in the legs	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Thyroid disease	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Stroke	☐ No	☐ Yes

PREVIOUS SURGERIES / PROCEDURES

Coronary bypass surgery	☐ No	☐ Yes, date: _____	Hospital: _____
Cardiac catheterization	☐ No	☐ Yes, date: _____	Hospital: _____
Angioplasty / Stent	☐ No	☐ Yes, date: _____	Hospital: _____
Pacemaker / Defibrillator	☐ No	☐ Yes, date: _____	Hospital: _____
Other surgery (s)	☐ No	☐ Yes, date and type of surgery:	

_____

_____

MEDICATIONS (Please list all medications you are currently taking)

Medicaton	size/mg	per day	Medication	size/mg	per day

ALLERGIES (Please list any allergies you may have)

_____

_____

Cardiovascular Consultants, P.C.

Diagnostic and Interventional Cardiology

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of children_____
Use of alcohol: ☐ Never ☐ Rarely ☐ Daily
Use of tobacco: ☐ Never ☐ Previously, but quit (year) _____ ☐ Current packs/day_____
Use of "recreational drugs": ☐ Never ☐ Yes

FAMILY MEDICAL HISTORY

Does anyone in your family have or had heart disease, stroke, heart attack, high cholesterol, high blood pressure, diabetes, sudden death, heart failure?

	Age	Disease(s)	Alive	Dead	If deceased, cause of death
Father	_____	_____	☐	☐	_____
Mother	_____	_____	☐	☐	_____
Siblings (list each)					
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____

REVIEW OF SYSTEMS

CARDIOVASCULAR

PHYSICIAN COMMENTS

Chest pain / angina	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath with walking or lying	☐ No	☐ Yes
Swelling feet, ankles, or hands	☐ No	☐ Yes
Wake up during night with difficulty breathing	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Asthma / wheezing	☐ No	☐ Yes

VASCULAR / MUSCULOSKELETAL

Swollen legs, feet, ankles	☐ No	☐ Yes
Leg pain, walking or resting	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Joint pain	☐ No	☐ Yes
Cold extremeties	☐ No	☐ Yes

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever / chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

Cardiovascular Consultants, P.C.

Diagnostic and Interventional Cardiology

EYES — **PHYSICIAN COMMENTS**

Wear glasses / contacts	☐ No	☐ Yes
Blurred / double vision	☐ No	☐ Yes

EARS / NOSE / MOUTH / THROAT

Ringing in ears	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Sore throat / voice changes	☐ No	☐ Yes
Swollen glands	☐ No	☐ Yes

GASTROINTESTINAL

Loss of apetite	☐ No	☐ Yes
Rectal bleeding / blood in stool	☐ No	☐ Yes
Abdominal pain or heartburn	☐ No	☐ Yes
Peptic ulcers	☐ No	☐ Yes
Gall stones	☐ No	☐ Yes

GENITOURINARY

Problems urinating	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes

NEUROLOGICAL

Stroke	☐ No	☐ Yes
Blackouts	☐ No	☐ Yes
Numbness / tingling	☐ No	☐ Yes
Convulsions / seizures	☐ No	☐ Yes

HEMATOLOGICAL / LYMPHATIC

Anemia	☐ No	☐ Yes
Easy bruising	☐ No	☐ Yes

SKIN

Skin rash, swelling, itching	☐ No	☐ Yes

ENODCRINE

Glandular / hormone problems	☐ No	☐ Yes
Excessive thirst / urination	☐ No	☐ Yes
Heat / cold intolerance	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

MD Signature _____ Date _____

Cardiovascular Consultants, P.C.
Diagnostic and Interventional Cardiology

Samer Y. Kazziha, M.D. **Saba Darda, M.D.** **Rajesh Ramineni, M.D.**
Theodore L. Schreiber, M.D. **Sindhu Koshy, M.D.**

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to providing the best possible treatment.

Please complete the enclosed Patient Information Form. We will need all insurance information: NAME OF COMPANY, ADDRESS, PHONE NUMBER, POLICY NUMBERS, and POLICYHOLDER'S NAME and DATE OF BIRTH.
If you need assistance completing this form, we will be happy to help you at the time of your office visit.

Please bring in all current Insurance cards at the time of your appointment. We will need to be notified of any changes in your insurance, your address and/or phone numbers whenever they occur.

THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY:

EACH INSURANCE CARRIER HAS SPECIFIC RULES THE PATIENT AND DOCTOR MUST FOLLOW. IF THE PATIENT FAILS TO FOLLOW THESE RULES, SUCH AS OBTAINING AUTHORIZATION FOR THE VISIT, IT MAY RESULT IN NON-PAYMENT FROM THE INSURANCE CARRIER, AND WILL BECOME THE PATIENT'S RESPONSIBILITY.

If office visits are not a benefit of your insurance contract, payment is appreciated at the time of your visit.

We charge what is usual and customary for our area. We accept assignment of insurance benefits from many different insurance companies. Check with us if you have any questions regarding your insurance company.

If your insurance company requires co-pays and/or deductibles, you will be responsible for payment at the time of service. If co-pays are not made a $5.00 statement processing fee will be applied.

In rare cases some services may not be covered by your policy and could be your responsibility. We suggest that you check with your insurance company before any test is performed.

You will be responsible for supplying our office with any necessary referral forms at the time of your visit.

If you have any questions or concerns please let us know.

I have read the financial policy. I understand and agree to its terms. I, hereby authorize my insurance benefits to be paid directly to Cardiovascular Consultants, P.C., realizing I am responsible to pay non-covered services and I authorize the release of pertinent medical information to my insurance carriers.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____

37771 Schoenherr Rd, Suite 101 - Sterling Heights, MI 48312-2302 - Telephone (586) 698-1200 Fax (586) 698-1210
57850 Van Dyke Rd, Suite 400 - Washington, MI 48094-3826 - Telephone (586) 677-4606 Fax (586) 677-4661
1135 W. University Dr, Suite 230 - Rochester Hills, MI 48307-1871 - Telephone (586) 698-1200 Fax (586) 698-1210
8545 Common Rd, Suite 150 - Warren, MI 48093-6773 - Telephone (586) 573-7971 Fax (586) 573-4009

CARDIOVASCULAR CONSULTANTS P.C.

Authorization to Receive Communications from Cardiovacular Consultants PC

I, _____, authorize Cardiovacular Consultants to leave messages regarding my health care with the following person(s).

1. _____

2. _____

3. _____

4. _____

5. _____

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Witness	Signature	Date
_____		_____
Office Representative Signature		Date

CARDIOVASCULAR CONSULTANTS P.C.

Privacy Notice
Acknowledgement of Receipt

Patient Name: _____

Address: _____

Telephone: _____

E-mail: _____

Patient Number: _____

Social Security Number: _____

I acknowledge that I have recived a copy of the Privacy Statement from this office

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature Relationship to Patient

For Office Use Only:

Patient refused to sign

Patient unable to sign due to communication/ language barrier

Patient unable to sign due to emergency situation

Other (Please explain):

_____

_____

_____

_____ _____
Office Representative Signature Date:

CARDIOVASCULAR CONSULTANTS P.C.

NOTICE OF PRIVACY PRACTICES

September 2013

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
IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT
RHONDA KOKENOS AT 586-698-1205

Who will follow this notice

This noticed describes the information privacy practices followed by our employees, staff and other personnel.

Your Health Information

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive. Your health information may include information created and received by Cardiovascular Consultants PC(CVC), may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health related information.
We are required by law to give you this notice. It will tell you about the ways in which we may use and disclosed health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How we may use and disclose health information about you

We may use and disclose health information for the following purposes:

For Treatment:
We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.
Different personnel at CVC may share information about you and disclose information to people who do not work for CVC in order to coordinate your care, such as phoning in prescriptions to your pharmacy or scheduling tests for you. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For Payment:
We may use and disclose health information about you so that the treatment and services you receive at CVC may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations:
We may use and disclose health information about you in order to fun CVC and make sure that you and our other patients receive quality care.
For example, we may use your information to evaluate the performance of our staff in caring for you. We may also use it to help us decide what additional services we should offer or how we can become more efficient.
We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

Special Situations

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirement and limitations:

To avert a Serious Threat to Health or Safety.
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health of the public or another person.
Required by Law
We will disclose health information about you when required to do so by federal, state or local law.
Research
We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
Organ and Tissue Donation
If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
Military, Veterans, National Security and Intelligence
If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation
We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.
Public Health Risks
We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products
Health Oversight Activities
We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and

federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are

Family and Friends

We may disclose health information about you to your family members and friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information t your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

Other Uses and Disclosures of Health Information

We will not use of disclose your health information for any purpose other than those identified in the previous sections with your specific, written *authorization*. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.

If you give us authorization to use or disclose health information about you, you may revoke that authorization **in writing**, at any time. If you revoke your authorization we will no longer use or disclose information about you for the reasons covered by your written authority, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

Uses and Disclosures that Require us to give you an Opportunity to Object

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Cardiovascular Consultants PC in order to inspect and/or copy records of your health information. If you request a copy of your information, we may charge a fee to the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to Cardiovascular Consultants PC. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend.

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Cardiovascular Consultants PC.

To request an amendment, complete and submit a letter requesting the correction to Cardiovascular Consultants PC.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

-We did not create, unless the person or entity that created the information is no longer available to make the amendment

-Is not part of the health information that we keep

-You would not be permitted to inspect and copy

-Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. We have the right to file a rebuttal responding you yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for the purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request in writing to Cardiovascular Consultants PC. It must state a time period, which may not be longer than six years. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use of disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

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 emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes.

There may be instances where we are required to release this information if required by law.

To request restrictions, you may submit a letter requesting restriction on use/disclosure of Medical information to Cardiovascular Consultants PC.

Right to Opt Out

Fundraising activities by CVC. If you do not want us to contact you for fundraising efforts, please contact us at 586-698-1200

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to Cardiovascular Consultants PC. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice.

You may ask us to give you a copy of this notice at any time. To obtain such a copy contact Cardiovascular Consultants PC.

Changes to this Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will inform you of any significant changes to this notice. This may be through a sign prominently posted at our locations, a notice posted on our web site or other means of communication.

Breach of Health Information

We will inform you if there is a breach of your unsecured health information

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:
Office for Civil Rights