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Care Cardiology and Vein Center

Dr. Saleem Saiyad MD FACC

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_

Male \_\_\_ Female \_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Matrimonial Status : Single Married Divorced Widow (Circle one)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_Zip \_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address / Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nearest relative or person, we may contact in case of an emergency

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Carrier : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID or Subscriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID or Subscriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_

**Patient Agreement**

**Assignment of Benefits / Authorization for Treatment:**

I hereby authorize treatment and authorize direct payment of medical benefits to Care Cardiology and Vein Center for services rendered by Dr. Saleem Saiyad MD FACC, in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

**Financial Responsibility:**

I understand that I am responsible for all services rendered at the doctor’s rates. In the event that, insurance benefits are assigned to the doctor and billed to the insurer, I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree that it is my responsibility to obtain any prior approvals required by my insurance provider, and take all other steps to quality for insurance coverage. I agree that all charges are due upon billing. I understand that claims not paid or denied by my insurance carrier are my responsibility to pay to Care Cardiology and Vein Center. I agree that if referred to a collection agency or if legal action is necessary to collect my balance, I will be responsible for the doctor’s reasonable attorney fees and costs of collection.

I give consent to Care Cardiology and Vein Center, it’s authorized representatives, it’s physicians, providers, and/or independent physician contractors to provide medical services including diagnostic and radiologic procedures, administration of medications, and other treatment and care considered advisable or necessary for my care.

HMO Patients (Humana, Tricare, etc.) : If I have a Primary Care Physician (PCP) assigned by my insurance carrier, it is my responsibility to provide Care Cardiology and Vein Center with referral and/or authorization paperwork. Failure to do so can result in my medical claims being denied and my full responsibility to make a complete payment for care rendered.

**Release of Information:**

I authorize release and disclosure of all or any part of my medical records to any person or entity or representative thereof which may be responsible to pay for any portion of charges incurred, including but not limited to: private insurance carriers, federal or state agencies. I further authorize release of medical records to any physician, hospital, or any other person currently or subsequently involved in my healthcare. I authorize Dr. Saleem Saiyad MD FACC to obtain medical records needed to facilitate my diagnostic or treatment plan. This release may not be revoked during the course of treatment.

By signing below, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am obligated to adhere to all of the terms set forth herein. This agreement shall remain valid for all subsequent visits and all services after this date unless revoked in writing.

I have read this document or it has been read to me, and I understand and voluntarily accept its terms. If I am signing as the patient’s representative, I certify that I have the authority to do so.

**PRINT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Minute Cancellations and Missed Appointments:**

We do require a 24 hour notice on all cancellations. As a courtesy to our patients, we attempt to confirm all appointments. We do recognize that situations arise that are out of your control; however it is imperative that you contact our office immediately to notify us of your cancellation in a timely manner. Appointments canceled with less than a 24 hour notice or appointments not kept will be subject to a fee.

* $25.00 office visit
* $50.00 diagnostic imaging, such as an Echocardiogram, Venous ultrasound, Carotid ultrasound, etc..
* $50.00 Sclerotherapy or Ablations
* $80.00 for nuclear stress tests
* $500 for Angiogram procedure
* $25 for filing paperwork for leave or disability claims

Please be aware that your insurance does not cover this charge. Repeated “no show” appointments may result in referring you back to your insurance company for reassignment to another specialist.

**Late Arrivals:**

 If a patient is more than 10 minutes late for an appointment, the appointment needs to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available, but cannot compromise on the quality and timely care provided to our other patients.

I am aware of the no show and cancellation charges mentioned above. I understand that the office will make every attempt to place a courtesy reminder call for my appointments. However, regardless of whether a reminder call is provided, I am still responsible for attending my scheduled appointments.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient

**AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM TREATING MEDICAL PROVIDERS AND FACILITIES**

**I HEREBY AUTHORIZE** Care Cardiology and Vein Center to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that have provided care as my treating physician or facility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date of Birth Phone Contact Number

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of Care Cardiology and Vein Center to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_ I do not authorize Care Cardiology and Vein Center to release any information concerning my medical care to any individual except as set forth above.

\_\_\_\_ I do authorize Care Cardiology and Vein Center to release any or all information concerning my medical care to the following individual(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name- Please Print Name—Please Print

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient Relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number Phone number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

Care Cardiology and Vein Center has my permission to leave a voicemail message regarding my health information or my results at my phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please initial: \_\_\_ YES \_\_\_NO

**HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(PRINT NAME)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(SIGNATURE)**

**Patient History**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **Have you ever had?** | No | Yes |  | No | Yes | **Are you experiencing?** | No | Yes |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Hypertension |   |   | Hepatitis |   |   | Chills |   |   |
| Chest pain |   |   | Diabetes |   |   | Fever |   |   |
| Heart Attack |   |   | Anemia |   |   | Shortness of Breath |   |   |
| Irregular Heartbeat |   |   | Gout |   |   | Numbness |   |   |
| Pacemaker |   |   | Thyroid Disease |   |   | Extremity weakness |   |   |
| Cardiac Defibrillator |   |   | Phlebitis |   |   | Resting pain |   |   |
| Asthma |   |   | Stroke |   |   | Pain when walking |   |   |
| COPD/Emphysema |   |   | Cancer |   |   | Temporary blindness |   |   |
| Sleep Apnea |   |   | High cholesterol |  |  | Slurred speech |   |   |
| Kidney Disease |   |   | Fainting/Pass Out |   |   |  |   |   |

**Race: Check One**

|  | American Indian |  | Alaskan Native |  | Asian |
| --- | --- | --- | --- | --- | --- |
|  | African American |  | White |  | Native Hawaiian/Pacific Islander |
|  | Decline to report/Unreported |  |  |  |  |

**Ethnicity: Check one**

|  | Hispanic/Latino |  | Non Hispanic/Latino |  | Decline to report/Unreported |
| --- | --- | --- | --- | --- | --- |

**Nationality\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decline to Report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decline to Report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|

| Social History | Current | Past | How Much? |
| --- | --- | --- | --- |
| Alcohol |  |  |  |
| Illegal Drug Use |  |  |  |

**Please Check Correct Box**

| Tobacco |  Every daySmoker\_\_\_\_\_\_ |  Some daySmoker\_\_\_\_\_\_\_ |  FormerSmoker\_\_\_\_\_\_ |  NeverSmoked\_\_\_\_\_\_ |
| --- | --- | --- | --- | --- |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MEDICATION LIST** **(you can provide your own if available)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Medication Name** | **Strength** | **Frequency** |
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| **Surgeries & Date:** | **Height:** | **Allergies:** |
|  | **Weight:** |  |
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