ATRIA HEART
CARDIAC CLINIC & WELLNESS CENTER

16427 N. SCOTTSDALE ROAD, STE. 100
SCOTTSDALE, AZ 85254-8197
(480) 718-5072 • FAX: (480) 718-5074

PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you properly, we will need the following information. Information will be strictly confidential. (PLEASE PRINT)

Patient's Last Name: _____ First Name: _____ MI: _____

Legal Guardian/Health Care Proxy: _____ Living Will or Advanced Directive ☐ Completed ☐ Recorded

Birth Date: _____ Age: _____ ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Div Soc. Sec. #: _____

Local/Mailing Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Local/Home Phone #: _____ Business Phone #: _____ Cell Phone #: _____

Referred by: ☐ Physician _____ ☐ Self ☐ Family/Friend ☐ Other Health Professional ☐ Other _____

Employer: _____ Address: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Email: _____ Current or Previous Occupation: _____ Drivers License Number: _____

Local Pharmacy Utilized for Prescriptions: _____ Phone #: _____

Location: _____

Insurance: Company Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Policy #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Social Security #: _____

Secondary Insurance Company Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Policy #: _____ Group#: _____

Subscriber Name: _____ Birth Date: _____ Social Security #: _____

Person financially responsible for this account: ☐ Self ☐ Other

Other: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Business Phone #: _____ Cell Phone #: _____

Nearest friend or relative not residing with you: _____

Relationship to Patient: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone #: _____

Consent for Treatment and Authorization to Release Information

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize Atria Heart, PLLC to furnish my insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIPAA. I further authorize any holder of medical or other information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment.

Authorization to Pay Benefits to Provider

I request and authorize that payments for authorized Medicare/Other Insurance company benefits be made directly to Atria Heart, PLLC on my behalf for any services furnished to me by Atria Heart, PLLC who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 11288 0f the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Patient Responsibility

I agree that I am responsible for all charges incurred in this office. If my insurance coverage does not provide full benefits I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with Atria Heart, PLLC Further, I agree that this visit is not related to a litigation matter as it is my understanding that Atria Heart, PLLC does not see this type of case for evaluations and treatments. If cancellation of my appointment becomes necessary I will contact Atria Heart, PLLC no later than twenty-four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy that I may be subject to a charge of fifty dollars ($50.00) and such charge is not payable through my insurance. I have read the Atria Heart, PLLC Office Policy Statement and all my financial questions were answered.

Signature: _____ Today's Date: _____

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NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Atria Heart, PLLC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION ?:
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer of Atria Heart, PLLC at P.O. Box 13507, Scottsdale, AZ 85267-3507.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of November 1, 2014.

Received and Read: _____ Date: _____

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Please answer the following questions. All information provided is strictly confidential.

Patient Name: _____ Date: _____

D.O.B: _____ Name of Person/Physician making referral: _____

What is the purpose of your visit with us today? _____

Are you currently experiencing any symptoms? If so, please explain.

MEDICATION INFORMATION (Including Medication Allergies)	
Drug Allergies: Do you have any drug or latex allergies? ☐Yes ☐No	
If yes name the drug and the type of reaction (example rash, nausea, etc).	

Current Meds: (list any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

Patient Name:_____

Personal, Family & Social Medical History

Personal History

Diabetes ☐Yes ☐No If yes, when diagnosed? _____

High Cholesterol ☐Yes ☐No If yes, when diagnosed? _____

Asthma ☐Yes ☐No If yes, when diagnosed? _____

Obesity ☐Yes ☐No If yes, when diagnosed? _____

Thyroid Disorder ☐Yes ☐No If yes, when diagnosed? _____

Heart Attack ☐Yes ☐No If yes, when diagnosed? _____

High Blood Pressure ☐Yes ☐No If yes, when diagnosed? _____

Stroke/TIA ☐Yes ☐No If yes, when diagnosed? _____

Coronary Artery Disease ☐Yes ☐No If yes, when diagnosed? _____

Blood Clots ☐Yes ☐No If yes, when diagnosed? _____

Palpitations ☐Yes ☐No If yes, when diagnosed? _____

Chest pain ☐Yes ☐No If yes, when diagnosed? _____

Atrial Fibrillation ☐Yes ☐No If yes, when diagnosed? _____

Heart Catheterization ☐Yes ☐No If yes, when? _____

Other illnesses, including Gastrointestinal and Kidney: _____

_____

_____

Surgical History (please include the types & dates): _____

_____ _____

Other Cardiac history or Procedures: _____ _____

Family History

Is there a history of heart disease in immediate family (father, mother, siblings or children): ☐Yes ☐No

If yes, who? _____

Are any deceased? ☐Yes ☐ No Who and at what ages: _____

Social History

Do you currently or have you ever used:

Tobacco: ☐Yes ☐No If so, for how long: _____ Packs per day: _____ Year quit: _____

Alcohol: ☐Yes ☐No If so, how much: _____ How frequently: _____ Year quit: _____

Caffeine: ☐Yes ☐No If so, how much: _____ Type: _____ Frequency: _____

Do you exercise: ☐Yes ☐No How frequently: _____

_____

Patient Signature Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I have been presented with a copy of the **Notice of Privacy Practices,** detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

_____

Internal Use Only
If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Please name all person(s) we can contact and/or discuss your medical information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ Yes ☐ No The office may leave messages on any answering machine or voice mail associated with any telephone numbers (direct or cellular) identified by me in my patient information. List any restrictions to the information that may be left on answering machine or voice mail _____.

Following HIPAA patient confidentiality regulations, please check how you would like us to address you:

_____Mr. And/Or _____First Name

_____Mrs. _____Last Name

_____Miss _____Other_____

_____Ms.

Signature: _____ Date: _____