Valley Heart Rhythm Specialists, PLLC

(Huy M. Phan, MD PhD FHRS & Erica Brackin FNP-C)

595 N. Dobson Road Suite A5, Chandler AZ 85224 Tel: 480-534-7308 Fax: 480-534-7309

NEW PATIENT FORM

Last Name: _____ First Name: _____ MI: _____ Sex: M__ F__

DOB: _____ SSN _____

Home Phone: _____ Cell: _____ Work _____

Email Address: _____

Languages Spoken: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Other Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relation: _____ Phone: _____

(Emergency Contact Must Have Different Phone Number than Your Own Phone Number)

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Address: _____ or Cross Roads: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____ Member ID: _____

Group: _____ Group: _____

Insured Name: _____ Insured Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Primary Insured DOB: _____ Primary Insured DOB: _____

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PATIENT HISTORY

Reason for Visit: _____

Medical History:

Have you ever experienced or been diagnosed with the following?

Heart Attack (Coronary Artery Disease) (Myocardial Infarction) Yes __ No __ Year Diagnosed _____

Have you had stents placed? Yes __ No __ When? _____

Have you had bypass surgery? Yes __ No __ When? _____

Congestive Heart Failure Yes __ No __ Year Diagnosed _____

Heart Valve Disease Yes __ No __ Year Diagnosed _____

Have you had surgery for this illness? Yes __ No __ When? _____

Heart Arrhythmia Yes __ No __ Year Diagnosed _____

Have you had ablation/procedure for this illness? Yes __ No __ When? _____

Stroke Yes __ No __ Year Diagnosed _____

Cancer – What type? _____ Yes __ No __ Year Diagnosed _____

Lung Disease Yes __ No __ Year Diagnosed _____

Thyroid Disease Yes __ No __ Year Diagnosed _____

Social History:

Occupation: _____Retired: Yes _____ No _____

Employer: _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widow(er) ___ Life Partner ___

Do you have children? Yes ___ No ___ Number of Children: ____

Do you use tobacco? Yes ___ No ___ Quantity/Day _____Former (Year Quit) _____

Do you consume caffeine regularly? Yes ___ No ___ Quantity/Day _____Type: _____

Do you use alcohol? Yes ___ No ___ Quantity/Day _____Former (Year Quit) _____

Do you use illicit drugs (cocaine, methamphetamine, etc)? Yes ___ No ___ Former (Year Quit) _____

Do you exercise regularly? Yes ___ No ___ Times/Week _____Type:_____

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FAMILY HISTORY

Premature Coronary Artery Disease (Heart Attack) Yes ___ No ___ Relation: _____

(Diagnosed before age 55)

Diabetes Yes ___ No ___ Relation: _____

High Blood Pressure Yes ___ No ___ Relation: _____

High Cholesterol Yes ___ No ___ Relation: _____

Peripheral Vascular Disease Yes ___ No ___ Relation: _____

Other Health Problem _____ Relation: _____

Allergies:

Are you allergic to any medication? Yes ___ No ___

Medication Reaction (s)

_____ _____

_____ _____

_____ _____

Do you have any other allergies? (foods, tape, iodine, etc ...)

_____

List of Current Medications:

Medications Dosage How often?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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NOTICE OF PRIVACY OF HEALTH INFORMATION

Your privacy is utmost important to us. We record your information so that we can provide you with quality of care. We are committed to protecting this information. This privacy notice describes your rights and our purposeful use with regards to your health information

Your Rights Include:

-A right to mend your health information

-A right to request restrictions on what information we may use or disclose

-A right to see certain disclosures we have made of your health information

-A right to obtain access to your health information with limited conditions (an appointment for access, appropriate advance notice, and a cost based fee for expenses as delineated by law)

-A right to received a paper copy of our notice of privacy

We may use your health information and/or records to:

-Coordinate your care with other healthcare providers

-Submit bills to pay for your care

-Assist healthcare payers or insurance companies to make sure services are provided

-Disclose information to certain officials or organizations as required by law

Everyone who is trained or has access to your information is bound by your confidentiality requirements and signs a confidentiality agreement. We encourage you to read the notice and contact us for any concern or question.

I HAVE READ THE ABOVE AND ACCEPT FULL RESPONSIBILITY FOR THIS ACCOUNT

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize:

Valley Heart Rhythm Specialists, PLLC

595 N Dobson Road, Suite A5

Chandler, Arizona 85224

to receive and may disclose my health information including complete medical records, lab reports, studies reports, operative reports, etc... to my primary care physician(s), referring physician(s), or anyone I may specify.

I also authorize Valley Heart Rhythm Specialists PLLC (VHRS) to contact my listed emergency contact in case VHRS unable to reach me for my medical care, procedure schedule, and issues related to my health.

I understand that this authorization will expire if I am no longer a patient under Valley Heart Rhythm Specialists

I understand that I may revoke this authorization at any time by written notification

I understand that I can refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or my eligibility for benefits

Patient Name: _____

Date of Birth: _____ SSN: _____

Patient/Guardian Signature: _____ Date: _____

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MEDICAL RECORDS REQUEST

I, as signed below, authorize that my medical records be released to *Valley Heart Rhythm Specialists* for the purpose of my medical care.

Name:	DOB:
Please FAX records to: Valley Heart Rhythm Specialists **480-534-7309**	Faxed on behalf of patient by:
Request faxed on: _____/_____/_____	

Please FAX the following documents:

*Office notes (including the most recent note)

*Procedure notes/reports

*Diagnostic tests: EKG, Echocardiogram, Stress test, Holter/event monitor, and labs

I appreciate your prompt response to this request as it may affect my cardiac care.

Sincerely,

Patient's Signature: _____

Patient's Name: _____Date: _____

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PAYMENT AGREEMENT FOR ON-SITE PROCEDURES

(High Deductible Insurance Plans)

Patient Name:_____ **Patient DOB:**_____

Due to my yearly high deductible not being met for the current calendar year, I am required to make the following payments at time of service:

- **Echo: $200 is due at time of service.**
- **Stress Echo: $230 is due at time of service.**
- **Event Monitor Hook-up (MCOT): $600 is due at time of service.**
- **Loop Recorder: $4200 is due at time of service.**

******Only the cost of the service or your remaining deductible (whichever is LESS) will be collected. For example, if your remaining yearly deductible is $140, ONLY $140 will be collected for any or all procedures listed above. If your remaining yearly deductible is $4500, FULL cost of each procedure will be required until you satisfy your deductible.**

I understand that fees that are **NOT** paid at time of service will result in additional billing charges added to my account or my procedure would be rescheduled.

I understand that these charges are only **anticipated reimbursement** from my insurance plan; and I may be billed or refunded for any discrepancy from my Explanation of Benefits.

I have carefully and completely read this agreement and fully understand the purpose, intent, and effect of this agreement. I have voluntarily executed the agreement by action of my own free will.

Date_____ **Patient Signature**_____

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PRACTICE POLICIES

Failed Appointments ("No Show"):

1. If you are more than 20 minutes late for your appointment, we reserve the right to reschedule your appointment.
2. If you fail to cancel/reschedule your appointment within 24 hours of the scheduled time, **a "NO SHOW" fee of $30 for Office Visit, $50 for ECHO, ECHO Optimization, or STRESS TEST** will be applied to your account.

   ****A 15-minute late is considered NO SHOW for ECHO, ECHO Optimization, and STRESS TEST****
3. If you fail to cancel or reschedule your **HOSPITAL procedure within 48 hours** of the scheduled time, **a "NO SHOW" fee of $200** will be applied to your account.

Insurance verification:

1. Please make sure your insurance is **UP-TO-DATE, ACTIVE, AND IN-NETWORK** with our practice when checking in.
2. Physical insurance and ID card need to be present at time of service. **Patients are fully responsible if their claims are denied due to insurance being out of network, inactive/terminated or other reasons beyond our control.**

Insufficient Funds/Returned Check/Declined Credit Card transaction (on payment plan):

Returned check or declined credit card transaction will incur a **fee of $50** and will be applied to your account.

Copay/Balances:

You are responsible for all copays, deductibles, and charges not covered by your insurance(s). **We collect copay, high deductible, and balances at time of service**. Please notify billing office if you need to set up payment plan.

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Prior Authorization for Echo, Echo Optimization, Stress Echo, and Hospital Procedures:

Per insurance protocol, we obtain authorization for ALL above procedures. If your insurance APPROVES and provides a NO PRIOR AUTHORIZATION REQUIRED (NAR) but denies payment, you, as a patient, are fully responsible for **any charge or balance that your insurance allows and authorizes/approves but does not pay.**

Cardiac Clearance:

Please have the requesting physician's office send us the request **AT LEAST 7-10 BUSINESS DAYS** prior to your scheduled surgery.

Prescriptions:

Please request your Pharmacy to send us any refill request **AT LEAST 48 HOURS** for medications refills. Please avoid having prescription refilled over the weekend due to limited pharmacy hours and restrictions. By signing below, you authorize Valley Hearth Rhythm Specialists to routinely obtain a copy of your electronic prescription history.

Family and Medical Leave Act (FMLA) and Disability Forms:

Please allow our providers **AT LEAST 7-10 BUSINESS DAYS** for review and completion of forms.

Follow Up Appointments:

After the initial visit with Dr. Phan, your subsequent follow-up appointments may be alternated with Erika Brackin, our certified Nurse Practitioner. However, if you have urgent issues and would like to see Dr. Phan, we will try our best to accommodate.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____