New Patient Packet

Please Be Sure To Bring The Following To Your First Appointment:

- A PHOTO ID
- ANY/ALL INSURANCE CARDS
- CO-PAYMENT (IF REQUIRED)
- MAKE A LIST OF ALL CURRENT MEDICATIONS & DOSAGE.

We prefer the actual bottles; this allows us to see the strengths and dosage.

Please allow at least one hour for new patient appointments.

Please do not wear lotion on the day of your appointment. Also, ladies please "no" dresses. Two piece clothing is preferred. (This attire will allow us to perform the EKG)

It is very important that you complete your packet before your arrival.

We look forward to meeting you. Please call our office if you have any questions at (215) 747-4511.

Heart & Vascular Care Consultants

5600 Chestnut Street, Philadelphia PA 19139

215-747-4511

Welcome to our practice. We are pleased you have decided to let us attend to your Cardiac Health. You have an appointment with Dr._____on _____. The amount you will be required to pay at the time of service is $_____. This could be due to your copay, coinsurance and/or deductible.

Records: Your primary care physician has either agreed to send us records or given records to you. If you have the records please either mail them or drop them by so we can make sure they include the test our doctors require. Please complete the forms in this packet before your visit and bring them with you.

Previous Cardiac History: If you have already seen a Cardiologist (either here or elsewhere) it is important that we have those records also. Please obtain them and send us a copy. We need reports of any echocardiograms, heart caths, PTCA's, stents or bypass surgery you may have had.

Medicines: PLEASE BRING THE BOTTLES OF ALL MEDICINES YOU ARE CURRENTLY TAKING. Include vitamins, aspirin and other over the counter medicines.

Office Hours: We are open from 8:30 AM - 5:00 PM.

Prescriptions: When possible, have your pharmacy fax (not call) a request for refills. We will process the request within 48 hours unless it is faxed on the weekend.

Communication: We try to get back to patients who call as soon as possible. We do, however, see patients in the hospital and office and to avoid running chronically behind with our appointments most non-emergent calls are not returned until late in the day. We will call test results as soon as we have the report and it has been reviewed. This may take some time. If you have an office visit scheduled within a week or so of the test the doctor will discuss the results with you in person at that time.

Cancellations: If you need to cancel an appointment give as much notice as possible. There are always people who have new symptoms or problems and need to be seen.

Patient's Personal Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Age: _____ Country of Birth: _____

Referring Doctor/Person (include address if not local) _____

Briefly Describe the Reason for Today's Visit:

_____

_____

_____

_____

_____

Past Medical History:

Have you had any of the following?

	Yes	No	Year Began
Angina			
Heart Attack			
Other Heart Disease			
Rheumatic Fever			
High Blood Pressure			
Diabetes			
Lung Disease			
Cancer			
Nervous Breakdown			
Other			

Operations or Hospitalizations:

Description	Year

Family History:

	Age:	Alive?	Heart Disease?
Father			
Mother			
Brother			
Sister			
Sons			
Daughters			

Medications:

Name of Medicine	Dose	Times Per Day

Patient's Personal Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Mediation Allergies (Describe Reaction)

_____

_____

_____

_____ _____

Personal Habits:

Do you smoke? _____

If yes, # of years? _____

Amount: _____

Frequency: _____

Cigarettes / Pipe / Cigars (Circle ones that apply)

Do you drink alcohol? _____

If yes, # of years? _____

Frequency: _____

Beer / Wine / Liquor (Circle ones that apply)

Have you ever used recreational drugs? _____

OTHER PROBLEMS: (Circle ones that apply) Chest pain, shortness of breath, leg swelling, cough, heartburn, dizziness, nausea, vomiting, diarrhea, burning or painful urination, weakness in arms or legs, loss of vision, headaches, other _____.

Patient's Registration Form

Patient Information

Name/First **M.I.** **Last** **Title**

_____

Street Address or PO Box **City** **State** **Zip**

_____

Home Phone **Work Phone** **Cell Phone** **SS#**

_____

Birthdate **Age** **Gender** **Race** **Marital Status** **Spouse's Name**

_____

Patient Employer **Patient's Occupation**

_____

Address **City** **State** **Zip**

_____

What local pharmacy do you use?

Pharmacy Name: _____

Pharmacy Address: (need at least street name) _____

City: _____ **Phone Number:** _____

Do you use a mail away Pharmacy? If yes, what is the name: _____

Would you like to be web-enabled so you can view your medical records online?

Yes _____ **No** _____ **Email address:** _____

Patient's Registration Form

Insurance Information

Primary Insurance Company **Phone Number**

_____

Street Address or PO Box **City** **State** **Zip**

_____

Insured's Name **ID #** **Group #** **Birthdate**

_____

Secondary Insurance Company

_____

Street Address or PO Box **City** **State** **Zip**

_____

Insured's Name **ID #** **Group #** **Birthdate**

_____

Do you want us to discuss your medical condition, including test results with anyone other than yourself? If yes, list up to three people below:

Name **Relationship** **Phone Number**

1. _____

2. _____

3. _____

Insurance Authorization and Assignment

I hereby authorize Heart & Vascular Care Consultants, to furnish information to Insurance Carriers concerning my illness and treatment and I hereby assign to the Physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by Insurance.

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient: _____

Witness (if signed by someone other than patient)

_____

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Cardiology Physicians originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided

a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purpose, and

the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Heart & Vascular Care Consultants is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Heart & Vascular Care Consultants reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Heart & Vascular Care Consultants change their notice, will send a copy of any revised notice to the address I've provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient's Signature: _____

Date: _____

Acknowledgement of Receipt HIPPA of Privacy Notice

I, have viewed the posted Notice Of Privacy Practices for Heart & Vascular Care Consultants and have been Advised of my Rights to have a written copy if I wish to have one.

I requested a written copy of the Notice of Privacy Practices.

I do not wish to have a written copy of the Notice of Privacy Practices

Sign: Date:

We attempted ro obtain written acknowledge of receipt of our Notice Privacy practices, but acknowledge could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgment
An emergency situation prevent us from obtaining acknowledgement
Other (Please Specify)

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please Document the date the time the notice was presented to patient and sign below.

Presented on (date and time):_____

By: (name and title):_____

Haytham Albizem, M.D. FACP. FACC

Authorization & Request To Release Medical Records

This authorization expires in 180 days or at the written revocation of the patient.

Date: _____

Patient Name:

_____

Date of Birth: _____ Social Security Number: _____

I, _____ request that my medical records be released to: (please circle) Dr. *Haytham Albizem* and mailed or faxed to:

Heart & Vascular Care Consultants
5600 Chestnut Street
Philadelphia PA 13139

Patient Signature:

_____

Patient Representative Signature:

_____

Relationship to Patient:

_____

Witness: (If other than patient)

_____

Name, Phone & Fax of Hospital:

_____

_____

_____

Name, Phone & Fax of Doctor:

_____

_____

_____

What type of records? (HRT Cath, Bypass, etc.)

_____

Date of procedures: _____

INSURANCE AND BILLING POLICIES

Due to the vast number of insurance companies and the complex rules and constant changes, we have prepared the following information to help you understand our polices.

If you have an insurance that requires an authorization for your office visit or any procedures, please make sure to contact your primary care physician prior to the visit so that we will not have to reschedule the appointment.

You are responsible for any co-payments or deductibles at the time of service. If your insurance company does not respond to the claim within 60 days the amount will be transferred to you for payment. It is your responsibility to contact your insurance company for payment (we will assist you if you have questions, however sometimes they will only pay once the patient has contacted them).

A $50 fee will be charged for any paperwork such as disability, etc. that must be prepared by our clinical staff.

Any Medical Records copied per your request will be charged at: $1.00 per page for the first 25 pages and then $.25 for each page thereafter.
We accept cash, local checks, VISA, MasterCard, and Discover Card. If you are unable to pay your balance in full, a payment schedule can be arranged with our insurance specialist.

We appreciate the opportunity to serve you and hope this information is helpful. If you have any questions please do not hesitate to ask us.