New Patient Information

Patient Name: ______________________________ Date of Birth: _________________________________

Social Security Number: _______________________ Driver's license number: _________________________

Marital Status: Married Single Divorced Widowed Other Gender: Male Female

Religion:____________________prefer not answer Ethnicity:_________________prefer not to answer

Home Address: ____

Street Apt Number

____

City State Zip Code

Telephone number: Home ( ) _______________________ Email:_______________________________________

Cell ( ) ________________________ Work ( ) _________________________

Preferred method of contact for appointment reminder: Home Call Mobile Call Mobile Text Email

Emergency contact (name/relationship/phone): ____

Insurance and Prescription Information- Please give cards to front desk

Primary Insurance Company: ________________________ Subscriber social security number ____________________

Subscriber Name _______________________________ Subscriber date of birth ____________________________

- -

Secondary Insurance Company: ________________________ Subscriber social security number ____________________

Subscriber Name _________________________________ Subscriber date of birth ______________________________

- -

Prescription insurance company (if different from primary) ____

Contract Number_______________________________ Rx Group Number_____________________________

Rx Bin_________ RX Phone number for Providers (on back of your card): ________________________

Medical History Form

Most recent: Height______________ Weight_______________

Medication **Allergies and Reaction** (use back of page if necessary):

____

Preferred Pharmacy (name/phone) ____

Family physician/PCP: ____

When was your last annual physical exam? ____

When was your last cholesterol check? ____

If you are taking Coumadin, who is monitoring it? ____

How were you referred to our practice? ____

Smoking history (circle): Never smoker Former light smoker Former heavy smoker Current smoker (packs per day?_)

Alcohol History (circle): Never drinker (Average 0 drinks per *week*) Social Drinker (less than 7 drinks per *week*)
Moderate drinker (7-14 drinks per *week*) Above average drinker (more than 14 drinks per *week*)
How many drinks per day?

Do you drink (circle all that apply): Coffee (# cups per day) Tea (# cups per day) 5 hour energy drinksMonster/red bull type drinks (# per day) Caffeinated soda (# cans per day)

Has anyone in your family ever had sudden cardiac arrest? NoYes -please describe: ______________________________

Do you have a family history of heart disease, heart attacks, heart stents or coronary artery disease? No Yes

If yes, please describe age and relation: ____

Please list any major surgeries (use back of page if needed):

What Surgery?	Approximately what year?	Where was is done?

Do you have any of the following medical problems (check all that apply)?

High blood pressure		High cholesterol	
Asthma/COPD		Congestive heart failure / CHF	
By-pass surgery or CABG		Atrial fibrillation / A-fib	
Previous heart attack		Thyroid problems	
Previous heart stents or angioplasty		Kidney disease	
Diabetes		Stroke	

HIPAA POLICY AGRREEMENT

By signing below you are authorizing Top Cardiology Associates of MI to disclose information about you for:

- Ordering diagnostic tests and procedures, and calling to give you the results over the phone.
- Authorizing the office to release prescription information to pharmacies over the phone.
- Use of your information to fulfill standard health operations such as billing your insurance carrier(s).
- Appointment reminders via telephone, cell phone, text message and/or email based on your preference
- Authorizing the office to release medical records to other medical facilities to coordinate your care

Revocation of consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. We will request this form be updated annually. If you have any changes to your release of information policy prior to its annual renewal it will be your responsibility to notify us and complete a new form.

Reservation of Right to Change Privacy Practices: Top Cardiology Associates of MI reserves the right to modify the privacy practices. I understand that Top Cardiology Associates of MI will notify me of these changes upon my next appointment.

Signature: I have reviewed this consent form and give my permission to Top Cardiology Associates of MI to use and disclose my health information in accordance with this consent ("Notice of Privacy Policies and Practices" available upon request).

1. ____

Signature of Patient (or Legal Guardian/patient representative –please write name) Date

RELEASE OF RECORDS

- Release of records on paper must be made in person by yourself or your legal representative and will never be released on a same day basis, except in medical emergencies. You will be asked to come back and pick up records when ready.
- Release of your medical information over the phone will only be provided to the people you list below. We cannot speak to anyone on your behalf unless they are written below or you present in person to update this form. Please specify if there is any health information or conditions you wish to be excluded for the individuals listed blow.

You may release my medical records over the phone (including test results and treatment plan) to the following:

Name	Relationship	Name	Relationship

ASSIGNMENT OF BENEFITS AND RELEASE OF INFRMATION

I hereby assign Top Cardiology Associates of MI any insurance or other third-party benefits available for health care services provided to me. I understand that Top Cardiology Associates of MI has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Top Cardiology Associates of MI, I agree to forward all health insurance and other third-party payments that I received for services rendered to me immediately upon receipt. I also authorize Top Cardiology Associates of MI to release any medical information requested by my insurance company to process a claim.

2. ____

Signature of Patient (or Legal Guardian) Date

PAYMENT POLICY

The information I've provided is accurate and true to the best of my knowledge. I understand that the verification of my insurance benefits is a courtesy and the estimated out-of-pocket expenses are not a written agreement or guarantee of the actual amounts that may be owed. I understand that I am responsible to pay all deductibles, co-payments, etc. according to my insurance provider for the services rendered to me. I understand that I am the final responsible party for the charges for services provided by Top Cardiology Associates of MI and I will assume total responsibility of payment in case that my insurance policy doesn't pay.

3. ____

Signature of Patient (or Legal Guardian) Date

Advance Directives

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation. Advance directives may be revoked or altered at any time by the patient. Clinicians who comply with such directives are provided legal immunity for such actions. Conversations with relatives, friends, and clinicians are most common form and should be thoroughly documented in medical record for later reference. Properly verified oral statements carry same ethical and legal weight as those recorded in writing. Other forms include instructional advance directives (such as a DNR orders, living wills).

Do you have an advance directive?

□*Yes.*

Please provide a copy to our office at your convenience. We will ensure this gets scanned to your medical records

□*No.*

Would you like a copy of the state of Michigan advanced directive form today? □*Yes.* □*No.*

A durable power of attorney for health care or health care proxy is a written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. This may include written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life- sustaining medical treatment.

Do you have a durable power of attorney?

□*Yes.*

Please provide a copy to our office at your convenience. We will ensure this gets scanned to your medical records

□*No.*

Would you like a copy of the state of Michigan advocate designation form today? □*Yes.* □*No.*

Consent to Leave Protected Health Information (PHI) on Voicemail

The HIPPA Privacy Rule permits health care providers to communicate with patients regarding their healthcare. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. The rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, providers limit the amount of information disclosed in these messages. Messages that contain specific patient PHI require the patient to sign an authorization form to receive these messages by phone, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPPA. For example, messages that contain PHI would be the doctor's specialty, test and lab results, medication information, payment information, treatment plans, patient condition/diagnosis information, and anything else that is considered patient condition, treatment, or payment related.

You may consent to have your PHI given to you by message from the physician's office by signing this form in the space provided below. You may choose to allow the office to leave PHI messages on your home phone, cell phone or both. It is your responsibility to follow up on any messages left on your home answering machine or your personal voicemail. The office will not be responsible for relayed information which is not accessed in a timely manner by the patient. I understand my HIPPA rights and agree that Top Cardiology Associates of Michigan may leave messages for me, including those containing PHI, at the number(s) noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information

☐ Confidential messages (such as normal test results, medication information, or treatment recommendations) may be left on my **home** answering machine/ voicemail.

HOME PHONE # ____________________________

☐ Confidential messages (such as normal test results, medication information, or treatment recommendations) may be left on my **cell phone** voicemail.

CELL PHONE # ____________________________

☐ Please do NOT leave personal health information in any of my messages

____

Signature of Patient (or Legal Guardian) **Date**

Patient Name (printed)________________________________

TCAM
Top Cardiology Associates of Michigan

Patient Name and DOB: ____

Please fill out completely and bring to your appointment to avoid medication errors.

We will ask you to verify your med list at **every visit**. This can be done in advance via Henry Ford MyChart.

Medication	**Dose**	Route	**Frequency**	Refill Needed

Cancellation Policy and Fee Assessment

Nuclear Lexiscan Stress Test and Nuclear Treadmill Stress Test:

- You MUST call AT LEAST 24 hours prior to your scheduled test in order to cancel. The chemical for this test is ordered specifically for you 24 hours prior to the test and cannot be returned. If you do not call to cancel 24 hour prior to your appointment you will be charged **$100.** This will not be billed to your insurance company. This fee will be assessed directly to you as a monetary fine for not giving appropriate notice to cancel your appointment and help cover the cost of the wasted medication.
- This fine will be charged every time you do not give appropriate notice
- You will also be charged if your test has to be cancellation due to failure to follow the pre-procedure instruction, including eating or using caffeine/tobacco prior to the test.
- If you do not give appropriate notice for cancellation you will be allowed to reschedule your test. If you do not give appriopriate notice of cancellation a second time, you will again be charged $100 AND you will be *required* to have another office visit with Dr. Goswami to discuss testing/reasons for not showing up before you are allowed to reschedule for a third time. If you give appropriate notice for cancellation you may reschedule up to three times.
- Please note, you will receive an automated call 2 days prior to your test giving you the option to cancel your test at that time. If you do not cancel at that time, you must call the office to cancel your appointment 24 hour prior to your schedule test time.

Echocardiogram, Carotid Duplex, AAA Screening, Treadmill and Echo Stress Tests, Venous and Arterial Dopplers:

- You MUST give AT LEAST 24 hours notice of cancellation in order to allow us to provide this testing spot to another patient in need. If you do not call at least 24 hours prior to your schedule test you will be charged **$50** per test. This will not be billed to your insurance company. This fee will be assessed directly to you as a monetary fine for not giving appropriate notice to cancel your appointment.
- This fine will be charged every time you do not give appriopriate notice and for EACH test you failed to cancel appropriately.
- Please note, you will receive an automated call 2 days prior to your test giving you the option to cancel your test at that time. If you do not cancel at that time, you must call the office to cancel your appointment 24 hour prior to your schedule test time.

Office Visits:

- You must call BEFORE your appointment to inform us that you will be unable to keep the appointment. If you do not call and do not show up, you may be charged **$20**. This will not be billed to your insurance company. This fee will be assessed directly to you as a monetary fine for not giving appropriate notice to cancel your appointment. The appointment you missed prevented another patient in need from being seen.
- Please note, you will receive an automated call 2 days prior to your test giving you the option to cancel your test at that time. If you do not cancel at that time, you must call the office to cancel your appointment prior to your scheduled time.

I have read the above policy regarding cancellation fees. I understand if I do not call 24 hours prior to my nuclear stress test I will be charged $100. I understand if I do not call 24 hours prior to any other scheduled testing I will be charged $50 per test. I understand if I do not call and do not show up for an office visit I may be charged $20*. I understand it is my responsibility to keep track of the appointments I schedule* and if the staff is unable to reach me to remind me of my appointment that is not adequate justification for a fee waiver. I understand this fee will be charged for every appointment and every time that I do not cancel appropriately. I understand I will personally be responsible to pay these fees and they will not be billed to my insurance company.

____ ________________

Patient signature Date