

PATIENT INFORMATION FORM

In order to best serve you, please provide us with the following information:

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| Patient Information (Please Print) | Today's Date: |
| Patient First Name: | |
| Patient Middle Initial: | Date of Birth: |
| Patient Last Name: | |
| Patient Street Address: | |
| City, State, Zip | |
| Home Phone: | Daytime/Cell Phone: |
| Social Security Number: | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | |
| Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other | |
| Email Address: <i>(Your email address is confidential and will not be shared outside of Midwest Heart Specialists)</i> | |
| May we communicate information to you via email? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| May we send test results to you via email? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| May we leave test results on your answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| How did you hear about MHS? | |
| Primary Care MD: | Primary Care MD Phone: |
| Emergency Contact Name and Number: | |

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| Primary Insurance Information |
| Insurance Name: |
| Insured's Employer: |
| Secondary Insurance Information |
| Insurance Name: |
| Insured's Employer: |
| Additional Insurance Coverage (if applicable) |
| Insurance Name: |
| Insured's Employer: |

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|---|
| Person Responsible for Payment (if other than Patient): |
| Assignment of Benefits: I certify that the above information is accurate. I hereby authorize my medical benefits to be paid directly to Midwest Heart Specialists and allow the release of medical information necessary to process insurance claims. |
| Patient Signature: _____ |
| Date: _____ |

MIDWEST HEART SPECIALISTS Medical History

Name _____

Date of Birth _____ Sex _____ Primary Physician _____

Chief Complaint (State reason for cardiac consultation) _____

Risk Factors

High blood pressure Yes No

Smoke..... Yes No
 Former Smoker

If yes or former smoker: No of years__ Packs/day__ Year Quit_____

High cholesterol..... Yes No
 On cholesterol drug

Diabetes..... Yes No

Exercise regularly..... Yes No

Family history of early heart disease (60 years or less)..... Yes No

Weight (20 lb over ideal)..... Yes No

Past Medical History

Heart attack..... Yes No

Angioplasty/stent..... Yes No

Congestive heart failure..... Yes No

Stroke/mini-stroke..... Yes No

Lung problems..... Yes No

Blood clots in legs or lungs Yes No

Hypothyroid/Hyperthyroid..... Yes No

Stomach problems (ulcer, hiatal hernia, gastric reflux)..... Yes No

Liver problems..... Yes No

Kidney, bladder, prostate problems..... Yes No

Rheumatic/Scarlet Fever..... Yes No

Carotid artery blockage..... Yes No

Eye problems (cataracts, glaucoma, macular degeneration, blind).... Yes No

Arthritis..... Yes No

Sleep disorder (sleep apnea)..... Yes No

Use CPAP or BiPAP machine..... Yes No

Psychiatric problems (anxiety, depression)..... Yes No

Other _____

Review of Systems (continued)

- Kidney/Bladder System..... Blood in urine
 Frequent urination at night
- Musculoskeletal..... Arthritic pain
 Calf pain with walking
 Low back pain
- Skin..... Leg swelling
 Rash
- Neurologic..... Transient blurred vision
 Weakness on one side
 Slurred speech
 Numbness
 Dizziness
 Fainting spells
- Hematology..... Bruise easily
 Bleeding problems

Have you had any of the following?

Recent hospitalization When_____ Hospital_____

Recent lab tests When_____ Lab_____

Cardiac tests Type_____

When_____ Where_____

Peripheral vascular ultrasound tests

Type_____

When_____ Where_____

Name_____

Financial Policy

Thank you for entrusting Midwest Heart Specialists with your cardiovascular needs. We strive to provide excellence in all aspects of patient care. In order to better serve our valued patients, we would like to familiarize you with our financial policy.

PPO Plans

Please verify with your insurance plan that your specific physician is contracted with your plan. We have several new physicians who may not yet be contracted with the plan. This will help to ensure your services will be paid by your plan at their highest rate.

We are required under our contract with the plan to collect any co-payments, deductibles or co-insurance. Most plans have a co-payment, which you are expected to pay at the time of service. We will bill you for any deductible or co-insurance amount.

HMO/POS Plans

A referral is required before any service is rendered. If you do not obtain a referral, you may either: 1.) Sign an unauthorized waiver stating that you are responsible for payment. or 2.) Reschedule the appointment until you receive the referral from your primary care physician. The HMO plans will not pay for your services unless you obtain a referral.

We are required under contract with these plans to collect any co-payment, co-insurance and deductible amounts. Co-payment is expected at the time of service. You will be billed for co-insurance and deductible amounts.

Self Pay

Unless you are member of one of our contracted plans, Medicare, or Medicaid, please be prepared to pay for services at the time of service. We accept cash, checks, Visa, MasterCard and Discover.

Missed Appointments

A \$50.00 fee will be billed to the patient for a missed appointment if the office is not notified of need to cancel or reschedule.

If you have any questions regarding our policy or your account, please contact our Patient Financial Services office at 630/268-3500. We are open Monday – Friday, between the hours of 9am and 5pm.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account for services rendered.

Patient/Legal Guardian _____ Date _____

MIDWEST HEART SPECIALISTS
NOTICE ACKNOWLEDGEMENT
(Provider)

Purpose: This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

SECTION A: Individual receiving Privacy Practices Notice.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Date of Birth: _____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

I acknowledge that I received the Privacy Practices Notice of **Midwest Heart Specialists**

Signature: _____ Date: _____

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION B: Good faith effort to obtain acknowledgement (complete only if individual refuses written acknowledgement of receipt of Privacy Practices Notice on this form or otherwise).

- Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful:
- _____
- Individual received the joint Privacy Practices Notice applicable to our organization from another participant in our organized health care arrangement. We are therefore not required to deliver a Notice or obtain an acknowledgement. Attach a copy of the acknowledgement, or the documentation of the unsuccessful good faith effort to obtain acknowledgement, from the participant who furnished the joint Notice.
- Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are not required to obtain an acknowledgement.

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include completed form in the individual's records.
Update HIPAA section in demographics section of practice management system