74 Thomas Johnson Drive, Frederick, MD 21702
• Phone (301)694-9033 • Fax (301) 694-6204
Website: CardiologyAssociatesofFrederick.com

Providers

Hitesh V. Patel, M.D., F.A.C.C.

Samir K. Ahuja, M.D.

Paresh K. Visana, P.A.-C

Megan E. Joy, P.A.-C

Alireza Hazrati, F.N.P.

Our mission is to provide excellent cardiac care to better the lives of our patients. Our expectation is that each patient is provided exceptional service, personalized care, and to develop relationships with referring providers and patients to maintain lifelong cardiac health.

Thank you for choosing Cardiology Associates for your cardiac needs.

In order to help make your upcoming office visit as easy as possible, we have enclosed necessary forms which should be completed ***prior*** to your arrival. We recommend that you personally deliver, fax, e-mail or mail the forms back to us.

Please also bring:

- **Insurance Cards**
- **Photo Identification**
- **Form of payment** (We accept cash, check, debit card, MasterCard, Visa & American Express)
- A list of all the medications you are currently taking
- Any medical records, blood lab work, and diagnostic testing that you may have done as it pertains to your visit. Feel free to drop these off at the office prior to your visit.

If you are bringing records in-person, **please give all records to the medical assistant when they are preparing you to see the doctor**. We will electronically scan these documents and return them to you. Following these instructions will greatly facilitate your visit.

We very much value our patients' time and will work to minimize your wait in our office.

Our hours of operation and other useful information are available on our website at CardiologyAssociatesofFrederick.com. If you have any questions or need to verify the location, please call our friendly staff.

We look forward to meeting you soon, and thank you for choosing us for your cardiac care!

Sincerely,

The Cardiology Associates of Frederick Team

CARDIOLOGY ASSOCIATES of Frederick

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Patient Information

(Please print clearly)

Patient's Name (Last) _____ (First) _____ (MI) ____
Nickname_____ Email_____
Sex □ M □ F Date of Birth ___/___/____ SS # _____
Address _____ APT #_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Primary Language* _____ Marital Status: M / S / D / W *(please circle)*
Race* _____ Ethnicity* Hispanic or Latino/ Not Hispanic or Latino *(please circle)*

* Requested under federal guidelines for "Meaningful Use" to optimize patient-specific treatment and counseling

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Emergency Contact _____ Relationship_____ Phone _____
May we discuss your medical condition with another person? □ Yes □ No
If Yes, Whom _____ Relationship_____
Primary Care Provider _____ Phone _____
Did a doctor refer you to us? If yes, Doctor _____ Phone _____
Preferred Pharmacy _____ **Location**_____
How did you hear about us? _____

Responsible Party *(Complete only if the patient is a minor/dependent)*
Guarantor Name _____ Relationship to Patient _____
Home Phone _____ Cell Phone _____ Work _____
Address _____ APT #_____
City _____ State _____ Zip _____
Guarantor SS # _____ Guarantor DOB ___/___/____ Sex □ M □ F

* We do not bill absent parents; the adult presenting the patient for care is the responsible party.

I hereby certify the above information to be true and correct to the best of my knowledge. I understand that I am responsible to pay for all services rendered to me, I grant permission to my physician to mutually exchange medical information with referring physician and/ or associates. I hereby authorize disclosure of my medical records to my insurance carrier to obtain reimbursement.

Signature: _____ Date: _____

Name: _____Date of Birth: _____

Review of Systems

Constitutional

Change in Appetite **YES NO**

Chills **YES NO**

Fatigue **YES NO**

Fever **YES NO**

Eyes

Blurred vision **YES NO**

Changes in vision **YES NO**

ENT

Headaches **YES NO**

Nasal congestion **YES NO**

Runny Nose **YES NO**

Sinus pain **YES NO**

Sore throat **YES NO**

Cardiovascular

Cardiac murmurs **YES NO**

Chest pain with exertion **YES NO**

Chest pain at rest **YES NO**

Irregular heartbeat **YES NO**

Respiratory

Painful respiration **YES NO**

Shortness of breath **YES NO**

Wheezing **YES NO**

Gastrointestinal

Abdominal pain **YES NO**

Blood in Stool **YES NO**

Diarrhea **YES NO**

Loss of appetite **YES NO**

Nausea **YES NO**

Vomiting **YES NO**

Allergic-Immunologic

Allergic Dermatitis **YES NO**

Frequent Illness **YES NO**

Sinus Allergy Symptom **YES NO**

Genito-Urinary

Dysuria (painful urination) **YES NO**

Frequency of urination **YES NO**

Impotence **YES NO**

Nocturia (frequent urination at night) **YES NO**

Neurological

Headaches **YES NO**

Gait Abnormality **YES NO**

Numbness of tingling sensation **YES NO**

Seizures **YES NO**

Musculoskeletal

Back pain **YES NO**

Joint pain **YES NO**

Muscle pain **YES NO**

Endocrine

Cold intolerance **YES NO**

Excessive thirst **YES NO**

Excessive urination **YES NO**

Heat intolerance **YES NO**

Weight gain **YES NO**

Weight loss **YES NO**

Hematology/Lymphatic

Easy bleeding **YES NO**

Easy bruising **YES NO**

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Name: _____Date of Birth: _____

Doctor that referred you to Cardiology Associates: _____

Do you have a previous cardiologist? **YES** **NO** If yes, please list their name: _____

Cardiologist Phone: _____ If known, please list the date of last apt: _____

What is the reason for your visit today? _____

_____

Please list any medication allergies:	Reaction to Medication:
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies: _____

Do you take any medications? **YES** **NO**

Please list all medication (s) including dosage (prescription, over-the-counter, and herbal): _____

_____

_____

_____

_____

Please list all significant medical history: _____

_____

_____

_____

_____

Please list all prior surgeries including the year: _____

_____

_____

_____

_____

Name: _____Date of Birth: _____

WOMEN: Please complete the following:

Number of Pregnancies: _____ Number of Cesarean Sections: _____

Number of Vaginal Deliveries: _____ Are You Currently Pregnant? **YES NO**

Do you take prescription blood thinners? **YES NO**

Do you take aspirin or anti-inflammatory medicines every day? **YES NO**

Have you had a heart valve replacement? **YES NO**

Have you have a catheterization? **YES NO**

Have you had CABG? **YES NO**

Are you allergic to latex? **YES NO**

Are you allergic to intravenous contrast (dye)? **YES NO**

Social History

Current Marital Status: S M W D Occupation: _____

Do you use tobacco products: **YES NO** Do you drink alcohol: **YES NO**

Type: _____ Beer Wine Liquor

Packs/day: _____ Daily Weekly Monthly Socially Rarely

How many years? _____ Amount: _____

Tried to quit? _____ Last Drink: _____

Years since quitting? _____

Passive smoke exposure? _____ Do you have and Advance Directive: **YES NO**

Do you have a family history of any of the following: (**Circle all that apply**)

Blood Disease
BPH (Prostate Enlargement)
Seizure Disorder
Thyroid Disorder
Urinary Tract Infections
Migraines
Eczema
Diabetes
Coronary Artery Disease
Hyperlipidemia
Inflammatory Bowel Disease
Renal Failure
Hypertension (High Blood Pressure)
Cerebrovascular (Stroke)
Cancer: Type 1._____
2._____
Which Family Member 1._____
2._____

Other: _____
_____
_____

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Authorization for the Release of Protected Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____

I authorize representatives from Cardiology Associates to release or obtain the health information as directed below:

Self (Patient)
Obtain from/ Release to:

Facility: _____

Address: _____

Phone Number: _____

Fax Number: _____

Release to/ Obtain from:

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Frederick, MD 21702
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This request applies to:

- All healthcare information.
- Healthcare information relating to the following treatment, condition, or dates:

- Other: _____

Signature: _____ Date: _____

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Authorization to Release Medical Information

Patient Name: _____
Date of Birth: _____ Phone: _____

I authorize Cardiology Associates to release my medical information to another person/ family member.

(This is separate from Emergency Contact and also does not include Doctors, see previous page for Medical Release)

Yes or No (If Yes) Name: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

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Payment Policy

Thank you for choosing Cardiology Associates as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments, coinsurance, and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a Collection Agency, a $100.00 collections processing fee will be added to any outstanding balance.

3. **Referrals.** It is your responsibility to know if you require a referral for your insurance policy and to provide it to us at the time of service. If you are seen and do not provide a referral you will be responsible for the claim balance.

4. **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Our practice is committed to providing the best treatment and care to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines.

For additional information or questions about this policy please contact:

Cardiology Associates Monday – Friday 8:30am-5pm

Signature: _____ Date: _____

CONSENT TO EMAIL AND ELECTRONIC COMMUNICATION

It may become useful during the course of treatment to communicate by email or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with **Cardiology Associates of Frederick** and its staff, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages;
- Your employer, if you use your work email to communicate with me*;*
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

If you are concerned about methods of communication that are more secured, please talk with **Cardiology Associates of Frederick** staff about ways to keep your communications safe and confidential. If you are willing to communicate electronically, with the understanding that it is unsecured and that your information may be accessed or intercepted by others, please proceed with signing the consent below.

CONSENT FOR TRANSMISSION OF PROTECTED INFORMATION BY NON-SECURE MEANS

I consent to allow **Cardiology Associates of Frederick** and its staff to use unsecured email, text, or other means of unsecured electronic communication to transmit to me the following protected health information:

Printed Name: _____ Email: _____
Signature: _____ Date: _____

I consent to allow **Cardiology Associates of Frederick** and its staff to use unsecured email, text, or other means of unsecured electronic communication to transmit to me the following protected health information:

- ☐ Information related to the scheduling of meetings or other appointments
- ☐ Information related to billing and payment
- ☐ Completed forms, including forms that may contain sensitive, confidential information
- ☐ My health record, in part or in whole, or summaries of material from my health record
- ☐ Other information