Suburban Vein Center

PREMIER CARDIOVASCULAR CONSULTANTS

1629 W. Big Beaver Rd. Troy, MI 48084	311 Mack Ave. Suite 61100 Detroit, MI 48201	12701 Telegraph Rd. Suite 202 Taylor, MI 48180	211 Walnut Blvd. Rochester, MI 48307

PATIENT INFORMATION

DEMOGRAPHICS		
NAME (LAST, FIRST, MI):	SOCIAL SECURITY _____-_____-_____	
ADDRESS:	CITY:	STATE:
DOB:	RACE:	MARITAL STATUS:
EMAIL:	HOME:	CELL:
EMPLOYER (IF APPLICABLE):		
PRIMARY CARE PROVIDER:	PREFERRED PHARMACY (INCLUDE LOCATION):	

INSURANCE POLICY HOLDER INFORMATION

We require that you present your current insurance card(s) at check in. Your insurance contract is an agreement between you and your insurance company. We will file with your insurance carrier; however, you are responsible for payment for deductibles, copayments, and any non-covered services. All payments are due at the time of service. CHECK HERE IF INSURANCE HOLDER **IS** PATIENT NAMED ABOVE AND SKIP TO NEXT SECTION

INSURANCE HOLDER'S NAME (LAST, FIRST, MI):	SEX:	
DOB:	SOCIAL SECURITY: _____-_____-_____	EMPLOYER:

INSURANCE INFORMATION
PRIMARY INSURANCE: CLAIMS ADDRESS:
SECONDARY INSURANCE: CLAIMS ADDRESS:
TERTIARY INSURANCE: CLAIMS ADDRESS:

EMERGENCY CONTACT INFORMATION		
PRIMARY NAME:	PHONE:	RELATIONSHIP:
SECONDARY NAME:	PHONE:	RELATIONSHIP:

FINANCIAL POLICY

By initialing below, I agree that I have read PCC's Financial Policy. I understand that I am expected to adhere to this policy. I am aware that payments are expected at time of service. **Initials:** **Date:**

AUTHORIZATION

I hereby assign payment directly to the designated provider for any medical procedures performed. I agree to be responsible for payment of services determined by my insurance company as not medically necessary or non-covered service(s). I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signature:_____ **Date:**_____

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CARDIOVASCULAR QUESTIONS

PATIENT NAME:_____

1) Have you ever had pressure, pain or discomfort in the chest or arm?

○ Yes ○ No

Where? (If no, skip to #12):

2) Is the pain produced by:

☐ Exertion (climbing, sexual intercourse, etc.)

☐ Exposure to cold

☐ Being upset

3) Does the pain wake you up at night?

○ Yes ○ No

4) Does the pain get worse with a deep breath?

○ Yes ○ No

5) Does the pain get worse by moving the arm or does it occur with special movement?

6) How long does the pain last?

7) How does it get relief?

☐ With rest

☐ With meals and milk

☐ With antacid

8) How long have you had recurrent chest discomfort?

9) How often do you have chest discomfort?

10) Is the pain associated with:

☐ Shortness of Breadth

☐ Dizziness / Lightheadedness

☐ Nausea and Vomiting

☐ Diaphoresis / Sweating

11) Have you ever had shortness of breath/cough in the middle of the night that woke you up?

○ Yes ○ No

12) Do you elevate your head with a pillow in order to breathe at night?

○ Yes ○ No

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13) Do you get shortness of breath when climbing stairs or walking?

○ Yes ○ No

13.1) How many blocks can you walk?

13.2) How many flights of stairs?

14) Have you ever had swelling in your ankles?

○ Yes ○ No

15) Have you ever had dizziness or blacked out?

○ Yes ○ No

16) Have you ever coughed up blood?

○ Yes ○ No

17) Do you wheeze?

○ Yes ○ No

18) Have you noticed palpitations (fluttering of the heart) or skipped beats?

○ Yes ○ No

19) Do you get pain in your calves when you walk?

○ Yes ○ No

20) Have you ever had a sudden blurred vision in one or both eyes?

○ Yes ○ No

21) Have you ever had a stress test / stress echo? (If YES when & where)

22) Have you ever had a cardiac cath or stent placement? (If YES when & where)

23) Have you ever been told that... (Check the box if YES)

☐ your blood pressure is high

☐ you have diabetes

☐ you have a heart murmur

☐ you have high cholesterol

☐ you have bronchial asthma

☐ you have gout

☐ you have rheumatic fever

24) Do you drink alcohol? (If YES, how much / frequency)

25) Do you smoke cigarettes?

○ Yes ○ No

25.1) If YES how many packs per day?

25.2) If YES how many years have you smoked? If NO have you smoked in the past? When did you quit?

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27) Have any of you blood relatives had: (please check where applies)

- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Sudden Death
- ☐ Bleeding Problems

28) Are you allergic to any drug or any substances? (If YES please list)

29) Are you currently taking any medications? (If YES please list all medications with your daily dosage and frequency)

30) Have you ever been hospitalized or had surgery?

○ Yes ○ No

31) Do you have any other complaints?

○ Yes ○ No

32) How were you referred to us? _____

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PATIENT CONSENT FORM

CHARGES FOR SERVICES RENDERED: All charges for office services are due at the time of my visit to Premier Cardiovascular Consultants, otherwise referred to as "PCC" or "Practice". If an insurance claim is filled by the Practice, I request that payment of all benefits be made on my behalf to the Practice.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

TREATMENT: I further authorize and consent to the Practice's physicians and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgement. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

EMERGENCY MEDICAL CARE: In the unlikely event that a life-threatening emergency occurs while I am in attendance at PCC in which emergency medical care or treatment is required, I hereby authorize the Practice and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment. I agree to be responsible for all medical and related costs associated with such emergency and follow- up medical treatment.

CANCELLATION: I agree that I will provide at least twenty-four (24) hour notice to the Practice when cancelling an appointment and understand that failure to provide such notice may result on a prolonged waiting period and/ or a cancellation fee.

PATIENT SIGNATURE: _____DATE: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____ give permission to the individuals(s) listed below to discuss my medical care with Premier Cardiovascular Consultants and pick up any documents at their office on my behalf. I have disclosed to the individual(s) that they must present a state or federal issued photo ID when picking up any and all documents on my behalf.

LIST OF NAME(S):

1. NAME: _____
   RELATIONSHIP: _____

2. NAME: _____
   RELATIONSHIP: _____

3. NAME: _____
   RELATIONSHIP: _____

4. NAME: _____
   RELATIONSHIP: _____

5. NAME: _____
   RELATIONSHIP: _____

PATIENT NAME: _____

DATE OF BIRTH: _____ CONTACT PHONE NUMBER: _____

SIGNATURE OF PATIENT: _____ DATE: _____

VALID FOR ONLY FIVE (5) YEARS UNLESS REVOKED BY PATIENT OR GUARDIAN

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AKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Treatment: The Practice may release/obtain any and all of your medical records concerning your care to/from other health care professionals, physicians, or hospital facilities providing care to you at any time. Payment activities: The practice may release any and all of your records to Medicare, Medicaid, any insurance companies, and/or third party payer or managed-care company.

Healthcare Operations: Your Physician or staff of the practice may discuss your condition with members of your family or other individuals named on your **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION** form. We may attempt to contact you at the phone number you have provided to us and we may leave message on your voice mail or answering machine device concerning appointments or tests results. In accordance with Federal Government Privacy rules implemented through the Healthcare Portability Act (HIPPA), you have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of the uses and disclosures we may make of your protected health information. We encourage you to read this consent carefully and entirely prior to signing. We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting:

Premier Cardiovascular Consultants
1629 W. Big Beaver Road
Troy, MI 48084
Phone: 248-480-0363

Right to Revoke: You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the office listed above. Please understand that revocation of this consent will not affect action we took in reliance on this consent prior to receiving your revocation. We may decline continuation of treatment if this consent is revoked.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____