Metropolitan Cardiovascular Consultants, LLC

Patient Registration Form

First Name: _____ Last Name: _____ M.I.: _____

Sex: ☐Male ☐Female Date of Birth: _____/_____/_____ Age: _____ SSN# : _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Ph: _____ Home Ph: _____ Work Ph: _____ Email: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Widowed ☐Divorced ☐Other Race: ☐White ☐African American ☐Asian ☐Native American ☐Pacific Islander ☐Mixed ☐Other / ☐Hispanic ☐non-Hispanic

Occupation: _____ Employer: _____ Work Address: _____

Primary Care Physician: _____ Referring M.D/Person: _____

Emergency Contact Information: I give permission to discuss my condition with persons listed below as need or in an emergency

#1 Name: _____ Relationship: _____ Phone: _____

#2 Name: _____ Relationship: _____ Phone: _____

Preferred Pharmacy:

Name: _____Address: _____City: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____Member ID:_____ Group #: _____

Policy Holder First Name: _____ Last Name: _____ D.O.B.: _____
Policy Holder Address: _____City:_____Zip:_____
Policy Holder Relationship to Patient: ☐Self ☐Spouse ☐Parent

Secondary Insurance Company: _____Member ID:_____ Group #: _____

Policy Holder First Name: _____ Last Name: _____ D.O.B.: _____

Policy Holder Address: _____City:_____Zip:_____

Policy Holder Relationship to Patient: ☐Self ☐Spouse ☐Parent

I, the undersigned certify that I (or my dependent) have insurance coverage with the above-listed plan and assign directly to Metropolitan Cardiovascular Consultants all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and will pay the balance if not paid by insurance in the allowed 60 days. I hereby authorize Metropolitan Cardiovascular Consultants LLC to release all information necessary to secure payment of benefits, including the diagnosis and records of any treatment or examination. I authorize the release of this information to third-party payers, the physician's billing service, and/or other health practitioners. I understand that unpaid balances may be turned over to a third party for collection. I authorize the use of this signature on all insurance submissions. I agree that all copayments, deductibles, or non-covered charges will be paid at the time of service. This shall remain valid until written notice is given by me to the office revoking this authorization.

Patient/Guardian Signature: _____ Date: _____

Metropolitan Cardiovascular Consultants, LLC

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information be used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, rights to understand and control how your health information is used.
"HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one more health care providers. An example of this would be a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

A Health Information Exchange, or HIE, is a way of sharing your PHI among participating physician offices, hospitals, labs, radiology centers, and other medical care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a Maryland-wide HIE. As a participant in CRISP, we may share and exchange information that we obtain or create about you for treatment and public health purposes, as permitted by law. This exchange of PHI can provide faster access to critical information about your medical condition. You may opt out of CRISP by calling CRISP at 1-877-952-7477, or by submitting a completed Opt-Out Form directly to CRISP by mail, fax, or through the CRISP website at www.crisphealth.org.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Next page ⇨

Metropolitan
Cardiovascular
Consultants, LLC

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 26, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Policy and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Policies from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at 301-595-0356 with any questions you may have.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Printed Name	Signature of Patient or Guardian	Date

Disclosure Consent

I wish to be called using the below number(s) regarding my test results, treatment plans, referrals and/or billing and payment information. The best telephone number(s) to reach me are:

Phone No:_____ ☐Home ☐Cell

Phone No: _____ ☐Home ☐Cell

I authorize Metropolitan Cardiovascular Consultants, LLC to disclose my Protected Health Information either verbally or via phone, fax, email, or paper copy to:

Name: _____ Relationship to Patient: _____

Address: _____Phone: _____

I understand that I have the right to revoke my permission at any time. I understand this permission remains in effect until the time I revoke it in writing.

Patient Signature: _____ Date: _____

Metropolitan
Cardiovascular
Consultants, LLC

Consent Form

Notice of Privacy Practice & Billing Procedures

Cancellation/No Show Policy for Doctor Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment. If an appointment is not canceled at least 24 hours in advance, you will be charged a $50.00 fee. *Your insurance company will not cover this charge.*

Cancellation/No show Policy for Procedures
Doses are ordered for nuclear procedures per patient ahead of time; therefore, last-minute cancellations can cause problems and added expense for the office. If these appointments are not canceled at least 24 hours in advance, there will be a charge of one hundred and fifty dollars ($150). *Your insurance will not cover this.*

Scheduled Appointments
We understand that delays can happen. If a patient arrives 15 minutes past their scheduled time, we will have to reschedule the appointment, or you will have to wait until the patient before your appointed time has been seen by the doctor. However, we must try to keep the other patients on time.

Referrals
If your insurance requires a referral from your primary care physician, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. We welcome you to call your primary care physician and have them fax your Maryland Uniform Referral to us at (301) 595-0359. Failure to comply could result in you being responsible for all visit costs incurred.

Deductibles, Co-pays, Co-insurance and Non, covered charges
Our practice participates in many insurance plans. Most insurances will have a "copay." Your insurance may also have a "deductible," which means the amount you are responsible for before insurance starts covering your medical cost. You may also have "co-insurance," which means you will be responsible for a percentage of the charges. If you have an amount remaining on your deductible, our office policy is to collect a deductible deposit of $ 150 for new visits, $90 for extended office visits, and $60 for follow-up visits. If the deductible applies to procedures, an amount will be estimated based on expected charges and collected before services are performed. Any amount that is over the reimbursed charges as confirmed by the Explanation of Benefits from the insurance company will be credited or refunded to your account. Co-pays, deductibles, and non-covered charges are due at the time services are rendered. It is your responsibility to understand your policy coverage.

Insurance Termination or Incorrect Insurance Information
If your insurance coverage terminates, becomes inactive or if you give the incorrect insurance information during the period you have received services, you will be liable to be billed for any office visits or procedures.

Account Balances
We require that patients with balances pay their account balances to zero (0) before receiving further services. If you have questions about your bill, you can speak with someone from the billing department. Patients with balances over **$100.00** must make payment arrangements prior to future appointments being made. Patients with delinquent collection accounts may be discharged from the practice. Credits to your account will be applied to future charges or refunded back to you.

Signature: _____ Date: _____

Metropolitan Cardiovascular Consultants, LLC

Health History Form

Today's Date: _____

Patient's Name: _____ Date of Birth _____/_____/_____

If you are currently experiencing any of the symptoms, PLEASE CHECK ALL THAT APPLY

General
Weight change Y□ N□
Loss of appetite Y□ N□
Fever Y□ N□
Weakness Y□ N□

Dermatology
Rash Y□ N□
Change in color of moles Y□ N□
Lumps Y□ N□
Easy bruising Y□ N□

Endocrinology
Tiredness Y □ N□
Excessive sweating Y□ N□
Heat intolerance Y□ N□
Cold intolerance Y □ N□

Neurology
Headache Y □ N □
Tingling or numbness Y □ N □
Tremors Y □ N □
Loss of balance Y □ N □
Excessive sleepiness Y □ N □

Ophthalmology
Diminished vision Y □ N □
Eye irritation Y □ N □
Drainage from eyes Y□ N□
Blurring of vision Y□ N □
Yellowing in the eye

ENT/Respiratory
Cold Y□ N □
Cough Y□ N □
Coughing blood Y□ N □
Nose bleed Y□ N □
Hearing loss Y□ N □
Change in voice Y□ N □
Sore throat Y□ N □
Ringing in ears Y□ N □
Postnasal drip Y□ N □
Loss of smell Y□ N □

Psychology
Tension/stress Y□ N □
Depression Y □ N □
Sleep disturbances Y□ N □
Memory loss Y□ N □

Gastroenterology
Nausea Y□ N □
Dry mouth Y□ N □
Loss of taste Y□ N □
Vomiting Y □ N □
Bloating /belching Y □ N □
Difficulty swallowing Y □ N □
Abdominal pain Y □ N □
Diarrhea Y □ N □
Constipation Y □ N □
Change in bowel habits Y □ N □
Blood in stool Y □ N □

Musculoskeletal
Joint swelling Y □ N □
Joint pain Y □ N □
Leg cramps Y □ N□
Joint stiffness Y □ N □
Muscle pain Y □ N □
Back pain Y □ N □

Genitourinary female
Heavy periods Y □ N □
Blood in urine Y □ N □
Difficulty urinating Y □ N □
Increased urinary frequency Y□N□
Urinary incontinence Y □ N □
Urinary urgency Y □ N □
Vaginal discharge Y □ N □
Irregular periods Y □ N □
Hot flashes Y □ N □

Genitourinary male
Blood in urine Y □ N □
Difficulty urinating Y □ N □
Increased urinary frequency Y□ N□
Urinary incontinence Y □ N □
Urinary urgency Y □ N □
Difficulty with erection Y □ N □
Difficulty with ejaculation Y □ N □

Past Surgical History: Please list all surgeries and dates of the surgery

Name of procedure, Location	Date

Hospitalizations: _____

Allergies: Please list all

_____

Metropolitan Cardiovascular Consultants, LLC

Medications: please include medication name, dosage, and how frequently taken

Name	Dosage

Family History :

	Father	Mother	Father's Parents	Mother's Parents	Siblings #	Children #
High Blood Pressure						
High Cholesterol						
Diabetes						
Heart Disease						
Stroke						
Cancer						
Mental Illness						
Deceased? (cause of death/age of death)						
Other (please specify)						

Social History:

Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Drink Caffeine? ☐No ☐Yes, _____cups/day

Tobacco Use? ☐Never ☐Not now, when quit? _____ ☐Yes, _____packs/day

Drink Alcohol? ☐No ☐Yes, _____drinks/day Frequency: _____

Use recreational drugs? ☐Never ☐Not Now ☐Yes, drugs used_____

Patient/Guardian Signature: _____ Date: _____