Welcome To Our Office

Central Arizona Heart Specialists

- ☐ ROBERT J. HAMBURG, M.D.
- ☐ ROGER D. BIES, M.D.
- ☐ RIZALDY J. VILLEGAS, M.D.
- ☐ SUNTHARO LY, M.D.
- ☐ ROBERT W. DAPPEN, M.D.
- ☐ SUNNY JHAMNANI, M.D.

Thank you for choosing our office.to serve you properly we need the following information. {Please print) All information will be strictly confidential.

LAST NAME	FIRST	MIDDLE	SEX	MARITAL STATUS		DATE OF BIRTH	AGE
			☐ MALE ☐ FEMALE	☐ SINGLE ☐ WIDOWED	☐ MARRIED ☐ DIVORCED		

MAILING ADDRESS - STREET	CITY	STATE	ZIP	HOME PHONE

PERMANENT ADDRESS - STREET	CITY	STATE	ZIP	HOME PHONE

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU	RELATIONSHIP TO PATIENT	PHONE

REFERRING PHYSICIAN	ADDRESS

WHAT IS YOUR CHIEF COMPLAINT?

IF CHILD, PARENT OR GUARDIAN'S NAME

NAME OF EMPLOYER	ADDRESS	BUSINESS PHONE

SOCIAL SECURITY NUMBER	DRIVER'S LICENSE	OCCUPATION

NAME OF SPOUSE	BIRTHDATE	SOCIAL SECURITY NUMBER

NAME & ADDRESS OF SPOUSE'S EMPLOYER	BUSINESS PHONE

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-ADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.

DO YOU HAVE MEDICAL INSURANCE? ☐ YES ☐ NO	PRIMARY INSURANCE CO. NAME & ADDRESS		
SUBSCRIBER NAME	IDENT. NO.	GROUP NO.	IS IT THROUGH YOUR EMPLOYER? 0 YES O NO

IS THERE SEC. INS. ☐ YES ☐ NO	SECONDARY INS. NAME & ADDRESS	BUSINESS PHONE
SUBSCRIBER NAME	IDENT. NO.	GROUP NO.

MEDICARE NO.	MEDICAID NO.

IF THIS IS A WORK RELATED INJURY, WE NEED EMPLOYER'S INDUSTRIAL INSURANCE COMPANY INFORMATION. IF YOU DO NOT HAVE THIS INFORMATION PLEASE CALL YOUR EMPLOYER.

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT INCLUDING INFORMATION DISCLOSED PERTAINING TO ALCOHOL OR DRUG ABUSE TREATMENT PROTECTED BY FEDERAL CONFIDENTIALITY RULES (43 CFR Part 2).
I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO CENTRAL ARIZONA HEART SPECIALISTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the SOCIAL SECURITY ACT:

CHARGES SHOWN BY STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS PROTESTED IN WRITING WITHIN THIRTY DAYS OF BILLING DATE. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR MEDICAL SERVICES RENDERED TO ME OR MY FAMILY, I/WE AGREE TO PAY REASONABLE ATTORNEY'S FEES OR OTHER SUCH COSTS AS THE COURT DETERMINES PROPER. I ALSO AGREE TO PAY ALL COSTS OF A COLLECTION AGENCY IF NEEDED TO OBTAIN PAYMENT.

AGREEMENT:THE ABOVE INFORMATION IS FOR THE PURPOSE OF OBTAINING CREDIT AND IS WARRANTED TO BE TRUE. I AUTHORIZE THE CREDITOR OR HIS AGENT TO MAKE A CREDIT INVESTIGATION, INCLUDING EMPLOYMENT VERIFICATION .

_____ (PRINT NAME)

_____ SIGNATURE _____ DATE

CENTRAL ARIZONA HEART SPECIALISTS

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PATIENT NAME: _____
PATIENT DATE OF BIRTH: _____
DATE ORDERED: _____

PERIPHERAL VASCULAR DISEASE QUESTIONNAIRE

Peripheral Vascular Disease (PVD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrowed or clogged. Please fill out this questionnaire to see if you have the symptoms of Peripheral Vascular Disease.
Circle Yes or No to the Following Questions:

1. *Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks, when you walk or exercise?....* **YES** **NO**
2. *If you answered yes to question number 1, does the pain subside with rest?* **YES** **NO**
3. *Do you have numbness and tingling in the arms or lower legs and feet?...* **YES** **NO**
4. *Are your fingers or toes pale, discolored, or bluish?...* **YES** **NO**
5. *Are your hands or feet cold to the touch?...* **YES** **NO**
6. *Do you have any painful sores or ulcers on legs or feet that don't heal?...* **YES** **NO**
7. *Have you had any previous surgeries or percutaneous interventions on your peripheral circulation?* **YES** **NO**

If yes, what surgery or intervention was performed?

_____

When was that procedure performed?

_____

CENTRAL ARIZONA HEART SPECIALISTS

PATIENT DATA SHEET

NAME: _____ **DATE:** _____

CHIEF COMPLAINT(S):

Cough, Wheeze	Yes	No
Palpitations, Rapid Pulse	Yes	No
Chest Pain or Tightness	Yes	No
Shortness of Breath	Yes	No
Breathing Trouble	Yes	No
Angina	Yes	No
High Blood Pressure	Yes	No
Congestive Heart Failure	Yes	No
Arrhythmia	Yes	No
Second Opinion	Yes	No

Other _____

_____

ALLERGIES: TYPE OF REACTION:

Demerol _____
Penicillin _____
Aspirin _____
Sulfa _____
Codeine _____
Tetanus _____
Iodine _____
Shellish _____
Morphine _____
Other/Foods: _____

_____

SURGERIES: DATE:

Tonsillectomy _____
Appendectomy _____
Gall Bladder _____
Hysterectomy _____
Hernia _____
Breast _____
Kidney _____
Prostate _____
Cardiac Cath _____
Bypass Surgery _____
Other: _____

_____

PERSONAL ILLNESSES

Pneumonia	Yes	No
Rheumatic Fever	Yes	No
Transfusions	Yes	No
Arthritis	Yes	No
Stroke	Yes	No
Venereal Disease	Yes	No
Jaundice or Hepatitis	Yes	No
Epilepsy	Yes	No
Serious Injuries	Yes	No
Valley Fever (cocci)	Yes	No
Tuberculosis	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Nervous Breakdown	Yes	No
Lung Problems	Yes	No
Cancer	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Ulcers	Yes	No
Personality Change	Yes	No
Emphysema	Yes	No
Gallstones	Yes	No
Cholesterol	Yes	No
Kidney Stones	Yes	No
Hiatus Hernia	Yes	No

Other:

_____

GENERAL:

Fever	Yes	No
Excessive Thirst	Yes	No
Sweats	Yes	No
Chills	Yes	No
Headache	Yes	No
Dizziness	Yes	No
Weight Change	Yes	No
Fainting	Yes	No
Fatigue	Yes	No
Sleep Problems	Yes	No
Poor Appetite	Yes	No
Ankle Swelling	Yes	No
Varicose Veins	Yes	No
Blood Clots	Yes	No
Numbness or Tingling	Yes	No

MEDICATIONS:

Vitamins	Yes	No
Thyroid	Yes	No
Allergy	Yes	No
Blood Pressure	Yes	No
Diuretics (Water Pills)	Yes	No
Aspirin	Yes	No
Heart Medicine	Yes	No
Blood Thinning Med	Yes	No

Other:

_____

HABITS:

Alcohol Yes ____ oz/wk No

Cigarettes, Tobacco, (Snuff, Pipe, Cigars) Yes ____ oz/wk No

____ Quit

Coffee Yes ____ cups/day No

Exercise Yes No

Other: _____

FAMILY HISTORY:

High Blood Pressure	Yes	No
Heart Trouble	Yes	No
Hay Fever/Asthma	Yes	No
Arthritis	Yes	No
Tuberculosis	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Anemia	Yes	No
Emphysema	Yes	No
Diabetes	Yes	No

Other:_____

_____

FAMILY HISTORY:	AGE:	STATE OF HEALTH:	CAUSE OF DEATH:
MOTHER			
FATHER			
GRANDPARENT(S)			
SISTER(S)			
BROTHER(S)			

Central Arizona Heart Specialists

NOTICE OF PRIVACY PRACTICES

This Notice Describes How Health Information About YOU (As A Patient Of This Practice) May Be Used And Disclosed And How You Can Get Access To Your Individually Identifiable Or Personal Health lnformation (PHI).

This information is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please Review This Notice Carefully

Our Commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you . We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Our practice must provide you with the following information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

We may use and disclose your PHI in the following ways:

- Treatment: Our practice may use your PHI to treat you by providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may request laboratory tests and use the results to reach a diagnosis. We might use your PHI in order to write a prescription and might disclose your PHI to a pharmacy.
- Payment: Our practice may disclose your PHI in order to obtain reimbursement for services, confirming coverage, billing or collection activities , and utilization review. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.
- Health Care Operations : Our practice may use your PHI to operate our business, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service.
- Appointment Reminders: Our practice may use and disclose your PHI to contact you to remind you of an appointment.
- Electronic Transmission : Our practice may display the office name, address and patient identifiable information on electronic transmission of insurance claims and statements.
- Release of lnformation to Family/Friends : Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

Use and disclosure of your PHI in certain special circumstances:

- For public health activities including reporting of certain communicable diseases.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes .
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or disaster relief.
- For Worker's Compensation or similar programs as required by law.
- Inclusive of any other instance required by Jaw.

Your rights regarding your PHI:

- Confidential communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
- Requesting Restrictions: You have the right to request a restriction in our use of disclosure of your PH treatment payment or health care operations.
- Inspection of Copies: You have the right to inspect and obtain copies of the PHI that may be used to make decisions about you, including patient medical and billing records.
- Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request MUST be made in writing providing a reason that supports your request.
- Accounting of Disclosures: All patients have the right to request an "accounting of disclosures" consisting of a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. For Example, the provider sharing information with the medical assistant, or the billing department using information to file your insurance claim.
- Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices.
- Right to File a Complaint: If you believe your privacy rights have been violated, you may file a written complaint with our office, or with the Department of Health and Human Services, or the Office of Civil Rights.
- Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain written authorization for uses and disclosures that are identified by this notice or permitted by applicable law.

Our practice is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change terms to our Notice of Privacy Practices and to make the new provisions effective for all the protected health information that we maintain.

For more information about HIPAA or if you have any questions about this notice, please contact:
Denise McBride, HIPAA Privacy Officer, Central Arizona Heart Specialists
333 N. Dobson Road Suite #11 Chandler, Arizona 85224 Phone (480) 899-2020

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have reviewed a copy of Central Arizona Heart Specialists Notice of Privacy Practices.

_____ _____

signature of patient/guardian/POA Date

Authorization to Release Information

Please provide us with the names of any person or persons we are allowed to share your medical information with, otherwise we **MAY NOT** do so even with a spouse or relative without this authorization.

I hereby authorize _____
to receive any information concerning my medical condition or treatment at Central Arizona Heart Specialists.

_____ _____

Patient's Signature Date Patient's Printed Name

For Office Use Only

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____ Initials:_____

Reason:_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Welcome To Our Office

Central Arizona Heart Specialists
333 N. Dobson Road Suite #11 Chandler, Arizona 85224

PLEASE SIGN THE FOLLOWING STATEMENTS TO BETTER ASSIST US IN FILING YOUR CLAIMS TO THE INSURANCE COMPANIES FOR PROPER PAYMENT.

1. PHYSICIAN NOTICE: "Medicare will only pay for services that it determines to be 'reasonable and necessary' under this section 8162(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service." It is possible, in your case; Medicare may deny payment for today's services under the program standards.

   BENEFICIARY AGREEMENT: I have been notified by my physician that he believes that Medicare may deny payment for the services performed today under the Medicare program standards. If Medicare denies payment, I agree to be personally responsible for payment.

   SIGNED _____

2. I certify that the information given by me in applying for payment under title XVIII of the social security act is correct. I authorize any holder of medical or other information about me to release to any insurance company and/or the social security administration any information needed for processing of expenses incurred by me while being under the care of Central Arizona Heart Specialists. I assign the benefits payable for services rendered to the physician here named and I request that payment of authorized benefits be made on my behalf. I further authorize said physician to submit claims on my behalf for payment to me if I elect to pay for services at the time they are rendered. I further understand that this authorization will remain in effect until it is otherwise rescinded in writing by myself of power of attorney.

   SIGNED _____

3. State law, A.R.S. § 32-1401.12 (ff) requires that a physician notify the patient that the physician may have a direct pecuniary interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and if these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

   In compliance with requirements of this law, (I/We) have a direct pecuniary interest in the diagnostic or treatment agency or the non-routine goods or services named below, goods, or services that (I/We) have prescribed are available elsewhere on a competitive basis.
   DIAGNOSTIC OR TREATMENT: Nuclear medicine Other

   THESE ARE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS AT: Chandler Regional, Banner Desert, Mercy Gilbert, etc.

   The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided. (I/We) will keep the signed original in your patient file.

   ACKNOWLEDGEMENT
   I have read these notices to patients, and I understand the disclosures.

   Printed Name _____ Signature _____

CENTRAL ARIZONA HEART SPECIALIST

Robert J. Hamburg, M.D. FACC, FSCAI
Roger D. Bies, M.D. , FACC, FSCAI
Rizaldy J. Villegas, M.D. FACC, FSCAI
Suntharo Ly, M.D.FACC, FSCAI
. Robert W.Dappen, M.D. FACC
Sunny Jhamnani, M.D.

Due to the new HIPAA regulations involving patients privacy and personal information security, it is now required that you sign this document if you wish that this office discuss your treatment and care involving your private medical record. This form is required if you wish us to speak with your spouse, other family members, or even friends depending on the individual situation. this form is only for private information such as lab results, other test results, or even medication issues.

Thank you,
Central Arizona Heart Specialists HIPAA Privacy Department

I _____ authorize Central Arizona Heart Specialists and their employees to discuss my treatment and care with the below named person or people including verbal, written or electronic ways of transmission.

Name: _____
Relationship: _____
Phone Number: (____) _____

Name: _____
Relationship: _____
Phone Number: (____) _____

Name: _____
Relationship: _____
Phone Number: (____) _____

Name: _____
Relationship: _____
Phone Number: (____) _____

I DO NOT WISH FOR MY INFORMATION TO BE GIVEN TO ANYONE _____

Patient Signature (Guardian): _____
Date: _____

Witness (Office Use Only) _____

******** Please be aware that this release is only valid for one year from the initial date signed, unless revoked in writing prior to that date*********