

PATIENT NAME: _____ DATE: _____ DOB: _____ Acct# _____



RECENT OR CURRENT SYMPTOMS QUESTIONS

Circle whether you have or have not had any of these problems recently or since last seen by CCS.

GEN	Decreased exercise tolerance	Y/N	GI	Frequent Nausea	Y/N
	Fatigue	Y/N		Abdominal Pain	Y/N
	Weight Loss	Y/N		Blood in Stool	Y/N
	Weight Gain	Y/N		Constipation	Y/N
	Decrease in Appetite	Y/N		Diarrhea	Y/N
SKIN	Documented Fever	Y/N	GU	Urination More than 2X at Night	Y/N
	Rash	Y/N		Blood in Urine	Y/N
	Hives	Y/N		Impotence (Men Only)	Y/N
EYES	Hair Loss	Y/N	MS	Chronic Back Pain	Y/N
	Blurred Vision	Y/N		Joint Pains	Y/N
ENT	Hearing Loss	Y/N		Muscle Weakness	Y/N
	Nose Bleed	Y/N	Unexplained Muscular Pains	Y/N	
	Hoarseness	Y/N	NEURO	Dizziness (Lightheadedness)	Y/N
RESP	Difficulty Breathing	Y/N		Frequent Headaches	Y/N
	Loud or Excessive Snoring	Y/N		Paralysis	Y/N
	Persistent Cough	Y/N		Speech Deficit	Y/N
	Wheezing	Y/N		Seizures	Y/N
CV	Coughing up Blood	Y/N	PSYCH	Depression	Y/N
	Heart Palpitations	Y/N		Anxiety	Y/N
	Excessive Difficulty Breathing w/Exertion	Y/N		Change in Personality	Y/N
	Chest Pain	Y/N	ENDO	Intolerance of Heat	Y/N
	Difficulty Breathing when Lying Down	Y/N		Intolerance of Cold	Y/N
	Waking up at Night w/ Shortness of Breath	Y/N		Excessive Thirst	Y/N
	Swelling of the Feet or Legs	Y/N	HEME	Prolonged Bleeding	Y/N
Fainting or Almost Fainting	Y/N	Excessive Bruising		Y/N	
	Pain in Leg Muscles with Walking	Y/N			

Please describe any other important symptoms or details here:

Please describe any Hospitalization or ER visit since you were last here:

Please list any prescriptions that need to be filled today:

Check One: 30 day supply 90 day supply

PLEASE SEND REPORT'S FROM TODAY'S VISIT TO THE FOLLOWING DOCTORS:

PATIENT SIGNATURE _____

PATIENT NAME: _____

Acct # _____

Medical History Questionnaire

Please list all medication Allergies _____

Please indicate whether any of the members of your immediate family have had any of these **medical conditions and the age** at which they occurred.

	Father	Mother	Sister1	Sister2	Brother1	Brother2	Other
Alive and well							
CVA/Stroke							
Diabetes							
Heart Attack							
Coronary Balloon or stent							
CABG (Coronary Artery Bypass Graft)							
Deceased							
Other							

Please check any of the medical problems below that you have or have had in the past:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure | |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Other Kidney Disease | <input type="checkbox"/> Stroke | |

Cardiovascular diseases:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Electrocardiogram | <input type="checkbox"/> Blood Clots in the Veins of the Legs | <input type="checkbox"/> Heart Valve Problems |
| <input type="checkbox"/> Aneurysm of the Aorta | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Known Heart Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other Abnormal Heart Rhythm |
| <input type="checkbox"/> Blockage in the Neck Arteries | <input type="checkbox"/> Heart Murmur | |

Procedures or Tests: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> ABI (ankle-brachial indices) Exam | <input type="checkbox"/> Electrophysiology Study | <input type="checkbox"/> Leg Artery Balloon or Stent |
| <input type="checkbox"/> Aortic Aneurysm Surgery | <input type="checkbox"/> Heart Artery Balloon or Stent | <input type="checkbox"/> Neck Artery Surgery or Stent |
| <input type="checkbox"/> Cardiac Echocardiogram | <input type="checkbox"/> Heart Catheterization | <input type="checkbox"/> Pacemaker Implantation |
| <input type="checkbox"/> Cardiac Stress Nuclear Scan | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> Coronary Bypass Surgery (CABG) | <input type="checkbox"/> Holter Monitor or Event Monitor | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Defibrillator Implantation | <input type="checkbox"/> Left Arterial Surgery or Bypass | |

Please provide relevant dates for any heart disease, test, procedure, or surgery listed above:

Please fill in or circle and check the answers to the best of your knowledge:

1. Have you ever consumed alcoholic beverages? Yes No What type: Beer_ Wine_ Mixed Drinks_ Hard Liquor_ Year started/stopped? _____ Do you currently drink? Yes No How often do you drink: Daily/weekly/Monthly How many drinks per day? _____
2. Have you ever smoked? Yes No Tobacco Type: Cigars_ Pipes_ Smokeless Cigarettes_ Cigarettes_ Second Hand Smoke_ Year started/stopped? _____ Do you currently smoke? Yes No How often? Occasional (social) or Habitual (chronic) How many packs per day do you smoke? _____
3. Are you on any specific diet? Yes No If so, please list it here: _____
4. Do you drink caffeine? Yes No If so, how many cups per day? _____
5. Do you exercise? Yes No What type? _____ How often? _____
6. Have you ever used illicit drugs? Yes No Type: Marijuana_ Cocaine_ Narcotics_ Ecstasy_ LSD_ Heroin_ PCP_ Other: _____ Year started/stopped? _____ How often? Daily/weekly/monthly
7. Marital Status : Married Single Divorced Widowed
8. What is your occupation? _____ How many hours do you work per week _____
9. Living arrangements: Family Partner Retirement Community Friend Other _____
10. Women only: Are you menopausal? Yes No



**Authorization
for Release of Information**

Acct # _____

Patient Name

Date of Birth

Address

Telephone Number

I hereby authorize Capital Cardiovascular to disclose the following health information ...(check any that apply)

All Records	
Progress Notes	
Imaging Reports	
Two-way Verbal Exchange of Communication	
Laboratory Reports	
Test Results	
Other	

I authorize CCS to send all records to the Primary Care Physician and referring physicians as noted in my chart.

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/ drug (substance) abuse or any such related information.

I hereby authorize the information to be disclosed to the following physician or organization:

<u>Title</u>	<u>Name</u>	<u>Phone number</u>	<u>Relation to patient</u>
Family Member			
Healthcare Specialist			
Organization			
None <input type="checkbox"/>			

I understand that this authorization is voluntary and I may refuse to sign this release. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by PLLC my charge a processing fee for this service. This authorization will be in effect until _____ (date of event). If no date given, release will remain active.

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Capital Cardiovascular Specialists, PLLC. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient Representative

Date

Printed Name

Relationship to Patient **OR**

Legal Authority (attach supporting documentation)



Consent for Treatment

I do hereby consent to necessary examination procedures and/or treatments prescribed by my physician (Dr. Baldacchino, Dr. DeMaio, Dr. Williams, Dr. Frischhertz, and Dr. Gigliotti) and/or nurse practitioner (Kathryn Machuga FNP, and Marcy Smith ANP), their assistants, or designee as is necessary in their judgment.

Financial Responsibility and ACH Authorization

I understand payment is due in full at the time of service unless special payment plan arrangements have been made with our Business Services. If my insurance is a PPO/HMO with which Capital Cardiovascular Specialists contracts with, I am responsible for my co-payments, deductibles, and non-covered services. I understand that if my insurance carrier is one with which Capital Cardiovascular Specialists has a contract, that contract includes a provision for benefits to be paid directly to the group.

Assignment of Benefits

I understand that if my insurance is not contracted with Capital Cardiovascular Specialists, but I have made prior arrangements with Business Services, that in special situations, Capital Cardiovascular Specialists may file my insurance claims assigned. In such case, I authorize payment of benefits to be made to Capital Cardiovascular Specialists, PLLC.

Authorization of ACH Debit for NSF Checks

I authorize ACH debits if my check is returned unpaid by my bank for any reason. I authorize Capital Cardiovascular Specialists to initiate, directly or by agent, an ACH debit of my account, in the amount of the check, plus any bank fees incurred by Capital Cardiovascular Specialists, plus a collection fee in the amount between \$8.00 and \$40.00 as permitted by law. I understand that this authorization may be revoked at any time by providing written notice to Capital Cardiovascular Specialists.

No-Show Policy

Out of courtesy to other patients, there will be a \$25.00 fee for all consultations cancelled or rescheduled with less than 24 hour notice. For those patients scheduled for a nuclear test, there is a time sensitive chemical that will be wasted if you do not give at least 24 hours notice of your cancellation or rescheduling. Without enough advance notice, you will be charged \$142.00 for the chemical dose. This amount will not be covered by your insurance.

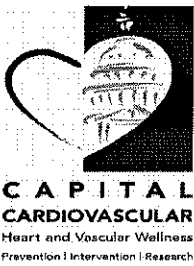
Form Completion and Copy of Medical Records

To cover the cost of Physician and Staff time to complete these request there may be an applicable fee. For more information please see a CCS representative.

Signed (Insured Person)

Date

Witness



Acct # _____

Patient Consent Form

By signing this form, you are granting consent to Capital Cardiovascular Specialists, PLLC to use and disclose your protected health information for the purposes of treatments, payment and health care operations. Our Notice of Privacy Practice (*Federal Register*, 45 CFR 164.520) provides more detailed information about how we may use and disclose protected health information about you.

You have the right to review our Notice of Privacy Practices before you sign this consent. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a revised copy by accessing our web site contacting our organization at 1-512-445-5998.

You have a right to request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to agree to this restriction. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient or Legal Representative: _____

Please Print Name: _____ Date: _____

Acknowledgement of Receipt of "Patient Notice of Privacy Rights" Summary Notice "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION."

As our patient, under HIPAA, the new federal privacy act, you have specific privacy rights. This notice is provided in 2 pages. This 1st page summarizes how we handle your health information, and contains the acknowledgement of receipt that we are required by law to attempt to obtain. The 2nd page contains the details about our privacy policies and procedures.

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting rooms. This is a summary notice of your rights.

A summary of your rights includes your right to:

- a. restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
- b. receive confidential communications in an alternate form or location
- c. inspect, copy, and amend protected health information (you may be billed for the cost of copying)
- d. know about any unauthorized disclosure of protected health information
- e. have a copy of our patient privacy notice

You must be given a copy of the "PATIENT NOTICE OF PRIVACY RIGHTS with REGARD TO HEALTH CARE INFORMATION", From Our Receptionist.

Signature Acknowledgement:

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from Capital Cardiovascular Specialists, PLLC.

Signature of Patient or Legal Representative: _____

Please Print Name: _____ Date: _____