**PATIENT’S NAME:** **DOB:** / / \_\_\_\_\_\_\_\_\_

**SOCIAL SECURITY** # \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ **SEX:** 🞏 MALE 🞏 FEMALE

**ADDRESS:** CITY: STATE: ZIP:

**PRIMARY PHONE:** ( ) - TEXT: 🞏YES 🞏NO (data rates may apply)

**SECONDARY LINE**: ( ) - TEXT: 🞏YES 🞏NO (data rates may apply)

**VOICEMAILS**: 🞏NONE 🞏 DETAILED 🞏RETURN CALL ONLY 🞏APPOINTMENT REMINDER ONLY

**OCCUPATION:**  🞏FULLTIME 🞏RETIRED 🞏DISABLED 🞏STUDENT

PATIENT EMPLOYER: PHONE: ( ) -

**MARITAL STATUS:** 🞏SINGLE 🞏MARRIED 🞏DIVORCED 🞏WIDOWED 🞏OTHER

**SPOUSE’S NAME**: DOB: / / 🞏Patient in the clinic

PHONE: ( ) - 🞏 Also Emergency Contact

**EMERGENCY CONTACT:** PHONE: PHONE: ( ) -

RELATIONSHIP:

**ADVANCED DIRECTIVE (65 & OLDER):** 🞏N/A🞏Power of Attorney 🞏Living Will

**PRIMARY CARE PHYSICIAN:** PHONE: ( ) -

**REFERRING PHYSICIAN**: \_\_\_\_\_\_ PHONE: ( ) -

**EMAIL** (Needed for patient portal set up): @ .

**LANGUAGE:** 🞏ENGLISH 🞏SPANISH 🞏OTHER

**RACE:**  🞏WHITE 🞏AFRICAN AMERICAN 🞏ASIAN 🞏AMERICAN INDIAN 🞏DECLINE

**ETHNICITY:** 🞏NOT HISPANIC 🞏HISPANIC 🞏DECLINE

**PRIMARY INSURANCE**: PHONE: ( ) -

ID #: \_\_\_\_GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**: PHONE: ( ) -

ID #: GROUP #:\_\_\_\_\_\_\_\_\_

**PRESCRIPTION INSURANCE**: \_\_\_\_ PHONE: ( ) -

ID #: BIN: PCN: GRP:

**LOCAL PHARMACY:**  PHONE: ( ) -

**MAIL ORDER PHARMACY:** PHONE: ( ) -

**Preferred Lab: 🞏Quest 🞏LabCorp 🞏Other**

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT, THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR’S FEES WITHIN 30 DAYS REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIMS. EXTENSION OR CREDIT BEYOND 30 DAYS MUST BE APPROVED BY THE BUSINESS OFFICE. CLAIMS WILL BE FILED TO YOUR INSURANCE COMPANY AS A COURTESY TO YOU.

I HEREBY AUTHORIZE NASSER CARDIOLOGY P.A. TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S) CONCERNING MY ILLNESS AND/OR TREATMENT PLANS. I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**REASON FOR YOUR VISIT:**

**ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?**

**General**

Headache

Lightheadedness

Fatigue

Weight Gain (unexplained)

Weight Loss (unexplained)

**Cardiology**

Shortness of Breath

Shortness of breath with exertion

Difficulty breathing while lying flat

Chest pain

Chest pain at rest

Chest pain with exertion

Dizziness

Swelling in Feet/Legs

Palpitations

**Gastrointestinal**

Blood in stool

Heartburn

**Hematology**

Easy bruising

Prolonged Bleeding

**Musculoskeletal**

Leg Cramps

Muscle Aches (generalized)

**Peripheral/Vascular**

Decreased sensation in arms/legs

Pain- Legs/Feet with exertion

Cramping-Legs/Feet with exertion

Pain in Legs/Feet at rest

Cramping –Legs/Feet at rest

Ulceration of legs or feet

Restless leg syndrome

**Skin**

Blistering of skin

Discoloration of skin

Rash

**Neurologic**

Balance Difficulty

Difficulty speaking

Fainting

Memory Loss

Loss of vision

Tremor

**Previous Cardiac Testing**

Electrocardiogram (EKG) Date: Where:

Echocardiogram (Ultrasound of Heart) Date: Where:

Stress Test Date: Where:

Holter/Event Monitor Date: Where:

Carotid Artery Ultrasound Date: Where:

Arterial Ultrasound- Legs / Arms Date: Where:

Venous Ultrasound - Legs / Arms Date: Where:

**Allergies**

🞏 **NKDA** – No Known Drug Allergies

Medication: Reaction:

Medication: Reaction:

Medication: Reaction:

Medication: Reaction:

Food: Reaction:

Food: Reaction:

**PAST MEDICAL HISTORY**

Please circle any of the following disorders that you **HAVE** been diagnosed with

NONE -No history

Atrial Fibrillation

Arrhythmia:

Aneurysm

BPH-Benign prostatic Hyperplasia

CAD-Coronary Artery Disease

Cardiomegaly (Enlarged Heart)

Cancer:

Carotid Artery Disease

Cardiac Arrest

CKD - Chronic Kidney Disease

Congenital Heart Disease

COPD

COVID -Date

Diabetes (Type I/ II)

DVT - Blood Clots in Vein

Endocarditis (infected heart valve)

Erectile Dysfunction

Fibromyalgia

GERD

Heart Attack

Heart Failure

Heart Murmur

Hiatal Hernia

High Cholesterol

Hypertension

Hypogonadism (male)

Migraines

Neuropathy

PAD - Peripheral Artery Disease

PVD - Peripheral Vascular Disease

PE- Pulmonary Embolism

Pulmonary Hypertension

Rheumatic Fever

Seizure Disorder

Sleep Apnea

Stroke or TIA (Mini Stroke)

Substance Abuse Drugs/Alcohol

Thyroid Disease

Varicose Veins

**Previous Cardiac Procedures**

**Pacemaker / ICD / ILR Implant** Date of implant: Manufacturer**:**\_\_\_\_\_\_\_\_\_\_\_\_**­­­­**\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_

Heart Catheterization Date: Where:

Heart Angioplasty/Stent Placement Date: Where:

Coronary Artery Bypass (CABG) Date: Where:

Heart Valve Replacement Date: Where:

Peripheral Artery Angiogram Date: Where:

Peripheral Artery Angioplasty/Stent Date: Where:

Peripheral Artery Bypass Date: Where:

Electrophysiology (EP) Study Date: Where:

Heart Rhythm Ablation Date: Where:

IVC Filter Date: Where:

Varicose Vein Ablation/Stripping Date: Where:

Sclerotherapy Date: Where:

Date: Where:

**Surgical History**

**Date Surgery Date Surgery**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Hospitalizations**

**Date Hospital Reason**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Family History**

**Relation Medical History**

|  |  |  |
| --- | --- | --- |
| Father  □Healthy | Alive Age \_\_\_\_\_  Deceased Age\_\_\_\_ | □Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother  □Healthy | Alive Age \_\_\_\_\_  Deceased Age\_\_\_\_ | □Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Siblings  □Healthy | Brothers \_\_\_\_\_  Sisters \_\_\_\_\_\_ | □Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Children  □Healthy | Son\_\_\_\_\_\_  Daughters\_\_\_\_\_ |  |
| Paternal Grandparent’s | □Healthy |  |
| Maternal Grandparent’s | □Healthy |  |
| Other |  |  |

**SOCIAL HISTORY**

**Tobacco Use**: 🞏Never 🞏 Currently 🞏Former smoker (how long did you smoke):

If YES, how many Packs/Cigarettes/Cigars per day or week: 🞏1/2pk ppd 🞏1pk ppd 🞏

Smokeless Tobacco Type: 🞏None 🞏Chew 🞏 Vape 🞏Other

**Alcohol Use:** 🞏No 🞏Yes 🞏Sober If YES how often: 🞏 Daily 🞏Weekly 🞏Social 🞏Occasionally

Choice of alcohol: 🞏Beer 🞏Hard Liquor 🞏Wine

**Caffeine Use:** 🞏No 🞏Yes Type: 🞏Coffee 🞏Tea 🞏Soda 🞏Energy Drink

If so how often: 1 2 3 4 5 per day

**Recreational Drug Use:** 🞏NO 🞏Yes Type: Frequency:

**MEDICATIONS**

Please list **ALL** medication you currently have a prescription for

Medication Dose Frequency Prescribing Doctor

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list **ALL** Over the Counter Medications, Vitamins, and Supplements

Medication Dose Frequency Prescribing Doctor

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Authorization for Disclosure of Confidential Information**

**Patient Name:**

**Date of Birth: SSN:**

**Address:**

**I hereby authorize Nasser Cardiology, P.A. to:**

* **Release to**
* **Receive from**

**Name of Person or Facility:**

**Street Address:**

**City, State, Zip Phone:**

**Fax:**

* **History and Physical**
* **Lab Results**
* **Cath Reports**
* **Radiology Reports**
* **Nuclear Stress Test**
* **Echo Doppler**
* **EKG**
* **ALL RECORDS**

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**CONTACT CONSENT FORM**

I consent to Nasser Cardiology, P.A. releasing medical information to any specialist that I am referred to and/or that I have listed below as current providers for continuation of care.

Primary Care Physician (PCP): Phone:

Referring Provider: Specialty: Phone:

Medical Provider: Specialty: Phone:

Medical Provider: Specialty: Phone:

I consent to Nasser Cardiology, P.A. mailing bills to the listed Address.

I consent to Nasser Cardiology, P.A. Leaving Voicemails on the listed phone numbers.

I consent to Nasser Cardiology, P.A. Sending Text Messages to the listed Phone Numbers.(data rates may apply)

Nasser Cardiology, P.A. **MAY NOT** discuss my healthcare and **MAY NOT** discuss and/or make financial Arrangements with anyone, Other than Myself, except as permitted by HIPAA and other applicable laws.

Nasser Cardiology, P.A. **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individuals listed below:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

I understand that if I would like to authorize Nasser Cardiology, P.A. to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

**Printed Name**: **Signature**:  **Date**:

If you are not the patient, please specify your relationship to the patient:

Please provide a date upon which this Authorization will expire. **Please mark only one selection**.

🞏 No Expiration

🞏Date of Expiration \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I voluntarily give my permission to the health care providers of Nasser Cardiology, P.A. and such

Assistants as they may deem necessary to provide medical care services to me. I understand that by signing below, I am authorizing them to treat me as long as I seek care Nasser Cardiology, P.A. providers, or until I withdraw my consent.

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Act of 1996 (HIPAA)/ I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare

Providers involved in my treatment);

* Obtaining payment from third party payers (ex my insurance company);
* The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I May contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time.

However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I , hereby acknowledge receipt of Nasser Cardiology, P.A., Notice of privacy practices. The Notice of Privacy provides detailed information about how Nasser Cardiology, P.A., may use and disclose my confidential information.

I understand that Nasser Cardiology, P.A., reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**INSURANCE BENEFIT INFORMATION AGREEMENT & WAIVER**

This information is being provided to help you better understand the process of receiving benefits. We are providing an estimate of your benefits, not an exact quote of what you will owe.

* **We can only ESTIMATE your benefits, as your insurance company applies a disclaimer when quoting benefits “actual benefits will not be considered until a claim is filed.”**
* **We share information we obtain from your insurance company with you and explain these to the best of our ability.**
* **If you still do not understand how your benefits are administered, it is YOUR responsibility to contact your insurance directly.**

**Please initial below that you have read and understand this policy.**

When making an appointment, it is your responsibility to confirm with your insurance company that Dr. George Nasser is currently under contract with your plan. If your plan requires a referral and you or your primary care provider do not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

All patient financial responsibility is due at the time services are rendered. Any balances determined by your insurance company will be due at each visit. Please call our office prior to each visit if you need to know in advance how much you will owe.

Any balances accrued after the insurance has responded to any claims are required to be paid 30 days after receiving a statement. If you have a past due balance at the time of service for an appointment or testing, you will be responsible for the balance during your visit.

I understand that Nasser Cardiology, P.A. does not accept Medicaid as primary OR secondary insurance coverage. I further understand that if I schedule an appointment and do not disclose that I am active with either of these plans OR I apply and receive Medicaid/Amerigroup benefits while under the care of Nasser Cardiology, P.A., I HEREBY AGREE TO PAY for any and all services I receive.

I have read, understand and have had an opportunity to ask questions regarding the information on this page and have a received a copy for my records.

**PLEASE READ THIS ENTIRE FORM PRIOR TO SIGNING OR INITIALING**

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient:

**OFFICE POLICIES**

Welcome and thank you for choosing Nasser Cardiology, P.A. for your health care needs. We look forward to serving you and strive to provide you with the best quality of care. Please carefully review the following valuable information as it is intended to serve as your guide to a smooth and productive visit.

**LATE ARRIVALS:** We do our best to keep the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.

**CHECK IN:** Your time is very important to you and us. The first step in keeping your appointment on time is being prepared. This includes filling out all the required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Forms. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15-20 minutes prior to your scheduled time so that all the paperwork may be completed PRIOR to seeing the physician. Although we verify your insurance benefits before your initial appointment, you must present your current insurance card along with a valid picture ID in order to verify your identity. This will ensure that all information is entered accurately and will prevent errors in filing claims. Without the insurance card, we will be unable to file with your insurance and you will be responsible for the charges. On EACH follow-up visit you will be asked to verify demographics and insurance information so that our records remain up to date.

**RETURN CHECK FEE:** There will be a return check fee of $35.00 posted to your account for all checks returned due to non-sufficient funds or closed accounts**.**

**MEDICATION HISTORY:** You are required to bring an UPDATED medication list EVERY visit, in which we will go over with you during the visit to ensure our records remain up to date.

**NO SHOWS AND LATE CANCELLATIONS**: We require a 24 hour advance notice if you must cancel your appointment. For your convenience, we offer appointment reminder calls 24-48 hours prior to your appointment which will allow you to cancel or reschedule at that time. If you NO-SHOW and appointment you may be subject to a $25.00 fee.

**Signature: Date:**

If you are not the patient, please specify your relationship to the patient: