Heart and Vascular Associates

Heart and Vascular Associates, LLC
130 Westmount Drive, Farmington MO 63640
573-756-1813, Fax 573-756-1868

Welcome to Heart and Vascular Associates, LLC. Thank you for choosing us for your cardiovascular needs.

Your appointment is scheduled _____ at _____ with _____.

We have enclosed our new patient documents which we know can be time-consuming but are critical to creating a successful first visit. We would greatly appreciate this information and your continued participation in your care. Below are some other key points to prepare you for your first visit.

1. Bring your completed new patient paperwork as completely as possible.
2. Bring your current insurance card and photo ID card.
3. Bring your co-payment amount with you as it is due at the time of service. We will accept cash, personal checks and all major credit cards.
4. Bring your medications in their original containers or a current medication list.
5. We have included a medical record release with your packet. Please sign, but do NOT complete or date. This form is a necessary requirement under HIPAA to allow other entities to release copies of your medical records to our office. We will keep this document on file to send to your other medical providers to obtain your records as needed in the future.
6. Please arrive 15 minutes before your scheduled appointment. Out of respect to your fellow patients, please note that if you arrive more than 15 minutes late for your appointment, it may be necessary to reschedule your appointment.
7. Finally, if your insurance company requires you to have a referral, please contact your Primacy Care Provider to secure it prior to your scheduled visit. If the required referral is not obtained in advance of your appointment, it may be necessary to reschedule your appointment until it can be obtained.

If you have any questions or comments regarding the paperwork, please feel free to contact us, and we would be happy to assist you.

Thank you for this opportunity to serve you. Throughout our partnership, please do not hesitate to contact us with regards to anything concerning your health or quality of care. It will be our pleasure to help you. We look forward to meeting you.

HEART AND VASCULAR ASSOCIATES, LLC

130 Westmount Drive, Farmington MO 63640

PATIENT INFORMATION

Please complete and/or verify all information and make changes as necessary.

Today's Date:		**Primary Care Physician Name:**			
Patient Name (First-Middle-Last)		**Date of Birth**	**Age**	**Gender** M F	**Marital Status** M S D W
Home Phone No.	**Cell Phone No.**	**Pt. Social Security No.**	**E-mail Address**		
Address Street #	**City/State/ZIP**	**Employment Status** Employed Unemployed Retired Student			
Name of Employer/School	**Occupation**	**Employer Address (Street-City-State-ZIP)**	**Employer Phone No.**		
Emergency Contact	**Relationship**	**Phone No.**	**Best # To Reach You During the Day** Home Cell Other (Pls. specify)		

GUARANTOR INFORMATION/ INSURANCE INFORMATION

Name of person who is financially responsible for this patient?	**Relation to Patient**	**Phone No.**	**Date of Birth**
Primary Insurance Co.	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**
Secondary Insurance Co.	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**

LEGAL GUARDIAN (IF MINOR)

Legal Guardian Name (First-Middle-Last)	**Address Street #**	**City/State/ZIP**	**Phone No.**

PATIENT DEMOGRAPHICS

Heart and Vascular Associates, LLC is participating in Meaningful Use. To better identify possible disparities in access and quality of healthcare based on race and ethnicity on a nation-wide level, we are required to ask the following demographic questions

RACE
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Caucasian
- ☐ Other
- ☐ I prefer not to report

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I prefer not to report

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other
- ☐ I prefer not to report

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign payment of authorized Medicare, Medicaid and/or any Insurance Carrier listed to include major medical benefits to which I am entitled, to be made on my behalf to Heart and Vascular Associates, LLC for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and/or any Insurance Carrier listed, any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Patient (Legal Guardian)'s Signature **Patient (Legal Guardian)'s Printed Name** **Date**

MEDICARE: Heart and Vascular Associates, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

INSURANCE: I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that all office co-pays are due at time of service. In addition, I agree to pay any additional charges related to the cost of collection including but not limited to collection agency fees, reasonable attorney fees and court costs, in the event that I would fail to pay my bill.

Guarantor's Signature **Guarantor's Printed Name** **Date**

HEART AND VASCULAR ASSOCIATES, LLC
130 Westmount Drive, Farmington MO 63640

Patient Name:_____

Risk Assessment

Coronary Risk Factors

	Yes	No
High Blood Pressure Medications:		
Diabetes Type:		
Smoker Packs per Day: Years Smoked:		

Possible Cardiac Symptoms (*occurring in the last 6 months*)

	Yes	No		Yes	No
Chest Pain (angina)			Leg/Ankle Swelling		
Shortness of Breath/ Wheezing			Blackouts/ Near Blackouts		
Chest Pressure/ Chest Tightness			Unusual Flutters (Palpitations)		

Family History

	Diabetes	Stroke	High Blood Pressure	Heart Attack
Father				Before 55: Y/N
Mother				Before 55: Y/N
Brother				Before 55: Y/N
Sister				Before 55: Y/N
Maternal Grandparent				Before 55: Y/N
Paternal Grandparent				Before 55: Y/N

Past Medical History

	Yes	No		Yes	No
Heart Disease/CAD			Thyroid		
Heart Attack			Insomnia		
Heart Cath/ Angiogram			Cancer		
Angioplasty/ Stent			Anxiety		
CABG			Inflammatory Disease		
Stroke/ TIA			High Cholesterol		
Blood Clots Medication/Filter:			Pacemaker/ Defribilator Type:		
Lung Disease			Peripheral Vascular Disease		

Patient Name: _____

PAST SURGICAL HISTORY: (*List any other surgeries you have had and the year*)

_____
_____
_____
_____

CURRENT MEDICATIONS: Please complete or provide a current medication list

Name of Medication	Dosage (mg)	Frequency (times per day)

PHARMACY NAME:_____PHONE NUMBER:_____
____ Yes ___ No I authorize Heart and Vascular Associates to download my complete prescription history into my electronic health record.

***Allergies/Reactions*:**_____

NATURAL/HERBAL REMEDIES:

_____
_____

VITAMINS/SUPPLEMENTS:

_____
_____
_____

OTHER/COMENTS:

_____
_____
_____

Heart and Vascular Associates

Heart and Vascular Associates, LLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

_____ _____

Patient Signature Date

HEART AND VASCULAR ASSOCIATES, LLC
130 WESTMOUNT DRIVE, FARMINGTON MO 63640
573-756-1818; FAX 573-756-1868

Patient Name: _____ **D.O.B.: _____**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge Heart and Vascular Associates, LLC and its staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Baxter Regional APRN Clinic operations and responsibilities.

_____

Signature of Patient/Guardian/Parent | Relationship of Patient Representative to Patient | Date

_____

Signature of Witness | Printed Name of Witness | Date

Permission to Contact and Release of Information

In order to improve communications between the office and our patients, an automatic service may be utilized to confirm your appointment or to leave messages regarding test results. Please check the following options below to receive your confirmation call:

_____ Phone reminders – Contact phone number _____

_____ Text reminders – Contact number _____

_____ Email Reminders* - Email address _____
*You must be registered with our E.H.R. Portal to utilize under HIPAA

Please note, patients who fail to keep appointments or fail to cancel appointments with 24-hour notice will be charged a $50 No Show/No Call fee for visits and testing and $100 for imaging stress tests. Appointments are in high demand, and your notice of cancellation allows us to give another patient access to timely medical care. If you need to cancel your appointment, please call 573-756-1813. If you do not reach a receptionist, please leave a detailed message on the voice mail or send a message through the portal.

There may be times when we need to speak to you personally regarding your appointment, to confirm your appointment, or to discuss your confidential health information. Please provide how and where you would like to be contacted. Please check the boxes below to indicate your preference.

_____I request that you leave a message on my voicemail but only to indicate you have called and I will return your call.

_____You may at any time speak with those below or release my confidential health information to: (If no names are listed, we will not release any information.)

_____

Name | Relationship to Patient | Phone Type | Phone Number

_____

Name | Relationship to Patient | Phone Type | Phone Number

_____

Signature of Patient/Guardian/Parent | Printed Name | Date

HEART AND VASCULAR ASSOCIATES, LLC
Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, our financial policy is in writing. For your convenience, we have answered some commonly asked questions below. If you have further questions, please contact our billing department.

Do I need to bring my insurance card with me to every appointment?
Yes. New patients must bring their insurance card at the first appointment. Established patients should also be prepared to present their insurance card prior to receiving service. It is the patient's responsibility to inform the staff of any changes in their insurance coverage at each visit. **Failure to provide correct insurance information may result in the balance becoming patient responsibility.**

Do co-pays need to be paid at the time of my appointment?
Yes. According to your contract with your insurance company, all co-pays are to be paid at the time of service. Refusal to abide by this agreement may result in rescheduling your appointment until the copay can be paid as required. We accept payment by cash and check, or credit/debit card.

What if my check bounces?
If a check is returned for insufficient funds, or if payment has been stopped, you will be charged a $35 fee in addition to the amount of the check.

What is your policy regarding missed appointments?
Patients who do not keep an appointment and do not call to cancel 24 hours or more before the scheduled appointment impact other patient's ability to obtain timely medical care. Therefore, patients who miss their appointments will be assessed a **$50** no show/no call fee. The no show fee must be paid prior to the patient's next appointment.

How am I to pay my portion after you bill the insurance?
Once we receive the Explanation of Benefits from your insurance company, we will bill you for the balance that you owe. That amount is due upon receipt of the statement. If you are unable to pay your balance in full, please contact the billing team to set up a payment plan. Patients enrolled in a payment plan and are compliant with monthly payments will not be subject to the collections process.

What if I do not pay my bill?
Accounts that are repeatedly ignored may be sent to collections. If this happens, you may have your credit adversely affected, and a collections status will be assigned to your account. Any future appointments will be scheduled with the expectation of payment on the outstanding balance PRIOR to the appointment. Ultimately non-compliance with payments will result in possible dismissal from the practice and you will be asked to find a new physician.

What happens if my account is in collections?
After multiple attempts through statements and letters, if there is no response from the patient, the balance will be turned over to an outside third-party collection agency. Collection attempts will continue through phone calls and letters, and ultimately without response from the patient this balance will be reported and will affect the patient credit rating.

What is my financial responsibility for services?
This varies with each insurance plan and patient. We suggest that you contact your insurance company for a detailed explanation of your copayments, coinsurance, and annual deductible requirements.

Patient Financial Policy
Acknowledgement

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays, deductibles and fees, are my responsibility. I authorize insurance benefits be paid directly to Heart and Vascular Associates, LLC and I authorize them to release any pertinent medical information to facilitate payment of a claim.

I have received a copy of this policy.

_____	_____
Signature of Responsible Party	**Date**
_____	_____
Printed Name	**Patient Name (if different)**

Heart and Vascular Associates, 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 and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fundraising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Tammy Johnson
Heart and Vascular Associates, LLC
130 Westmount Drive, Farmington MO 63640
Phone 573-756-1818 Fax 573-756-1868

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on September 23, 2013.

Heart and Vascular Associates

GENERAL INFORMATION

Emergencies: For a life-threatening situation, call 911 or proceed to the nearest emergency room. If you need to reach a physician after business hours for an urgent issue you may contact your provider directly by calling the exchange number 1-800-893-5434.

Prescriptions: To facilitate medication refills, we ask that you direct your pharmacy to electronically request refills. We make every effort to complete these requests quickly, but to ensure that you do not run out of medication, please call your pharmacy to request your refill a minimum of 48 hours in advance. If you need to contact the office regarding your medication, please call 573-756-1813, option 3. Patients must be seen by a provider annually to maintain refill authorizations of medications.

Appointments: We attempt to schedule your follow up appointment upon check out. If an appointment is needed or a change to your date and time, please contact the office, option 1. As a courtesy to our patients and staff, please call our office as soon as possible if you will be late. You may be asked to reschedule if you are more than 15 minutes late. Failure to cancel 24 hours prior will result in a No call/No show fee of $50 per appointment.

Physician Completion of Letters, Forms & FMLA paperwork: Please allow up to 10 business days for completion of forms. There may be a fee due for letters, forms and FMLA services and money will need to be collected before paperwork is sent or given out. Fees for forms and letters may be up to $50.00.

Insurance: While we accept many insurance plans, please contact the customer service number on the back of your insurance card to answer any questions regarding participation, plan benefits, co-insurance or deductible information that would be specific to the patient and the patient plan.
Please review insurance information with our staff prior to services being rendered. You will need to present your insurance card(s) at every visit; especially your first visit after the new year and when you receive new cards in the mail or change plans.

Test Results: We make every effort to contact you within a reasonable time regarding your test results, but if you have not received a call or message from our office within one week, please contact our office, option 3.

Change in Contact Information: Please notify our office of any changes in name, address, phone number, pharmacy and insurance information so we can always reach you and complete accurate billing.

Billing questions: If you have any questions regarding your balance or a statement you received, please contact our billing office directly at 1-877-432-2580.

Thank you for choosing our practice!

Heart and Vascular Associates, LLC
130 Westmount Dr., Farmington MO 63640
Phone 573-756-1813 Fax 573-756-1868

Medical Record Release Authorization

Patient Name:_____ Maiden Name:_____ SS#_____

Date of Birth:_____ Home Phone:_____ Cell/Work: _____

Address:_____ City/State/Zip: _____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone:_____ Fax:_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone:_____ Fax: _____

C) For the purpose of:

_____Litigation _____Disability

_____Insurance _____Work Comp

_____Self/Personal Copy _____Other

_____Transfer or Continuity of Care

Date Range_____ to_____

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____
- ☐ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drugabuse.

I understand that this authorization is value for up to 90 days. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Heart and Vascular Associates, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

No Show and Cancellation Policy

Cancellation of an Appointment

In order to be respectful of the medical needs of our practice patients, please be courteous and call promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call 24 business hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call (573)-756-1813. If you do not reach the receptionist, you may leave a detailed message on the voice mail.

Late Cancellations

Late cancellations will be considered as a “no show”.

No Show Policy

A “no show” is someone who misses an appointment without canceling it 24 business hours in advance of your scheduled appointment. (Example: your appointment is at 3 pm on Tuesday. You need to call by 3 pm on Monday). No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your chart as a “no show”.

A fee of $50.00 will be billed to your account and sent to your home. This fee covers administrative tasks associated with your appointment. This fee will need to be paid in full before scheduling any further appointments. Three follow-up “no shows” in a 12-month period of time will result in discharge from the practice.