

HEART CLINIC ARKANSAS
10100 Kanis Road
Little Rock, AR 72205

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

1. Who is authorized to use/disclose the information: _____

2. Who is authorized to receive the information: _____

3. Description of information that may be used/disclosed; and the dates of such information (for example, nurses notes from 01-01-01 to 01-15-01): _____

4. The information will be used/disclosed for the following purposes: _____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that Heart Clinic Arkansas may be paid for the costs of copying the information to be released.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Heart Clinic Arkansas except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

Signature of Patient or Representative

Date

Patient's Printed Name

Patient's Date of Birth

Patient's SSN

Name of Personal Representative (if applicable)

Relationship to Patient

Witness

Date



Patient Questionnaire

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: () _____

Daytime Phone: () _____ Mobile Phone: () _____

Social Sec. #: _____ Married Single Widow

Spouse's First Name: _____ Middle Initial: _____ Last Name: _____

Spouse's Social Sec. #: _____ Daytime Phone: () _____

Emergency Contact and Relationship: _____

Emergency Phone: () _____ Referring Physician: _____

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly describe your reason for consulting a heart doctor today:

Current Allergies:

Do you have ALLERGIES TO IODINE, seafood or radiographic contrast dye? YES NO

Please list any other allergies and describe the reaction:

Allergy to:	Reaction:
_____	_____
_____	_____
_____	_____

If more space is needed,
you can use the bottom of
the last page of this form.

Current Medications:

♥Remember to bring all medications with you at time of appointment

Please list all medications (prescription and non-prescription) that you are now taking or occasionally take:

Medication Name	Dosage	How Often Taken?	Who prescribed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

Please check if you had any of the following problems in the past:

Heart Attack?	_____	Congestive Heart Failure?	_____
Blackouts or Fainting spells?	_____	High blood pressure?	_____
Frequent dizzy spells?	_____	Rheumatic Heart Disease?	_____
Blood clots in veins or legs?	_____	Infection in the heart?	_____
Abnormal EKG?	_____	Blood clots in lungs or legs?	_____
Palpitations, skips, or irregular heartbeat?	_____	Abnormal heart rhythms?	_____
Pain in the arms, throat, jaw or upper back?	_____	Chest Pain, pressure, or tightness?	_____

Past Cardiac Procedures or Tests:

	Date	Location	Physician
Heart Catheterization (dye test)	_____	_____	_____
Heart Surgery (bypass, valve replacement)?	_____	_____	_____
Other blood vessel surgery?	_____	_____	_____
Electrophysiology Study?	_____	_____	_____
Pacemaker or AICD Implantation?	_____	_____	_____
Echocardiogram?	_____	_____	_____
Stress Test (Treadmill, etc.)?	_____	_____	_____
Holter Monitor?	_____	_____	_____

Past Medical Illnesses:

Please list any serious illness for which you have been hospitalized (except admissions just for surgery)

Past Surgeries:

Please provide the year for all that apply

Gallbladder _____	Tonsillectomy _____	Appendix _____
Hysterectomy _____	Prostate _____	Hernia _____
Breast biopsy or mastectomy _____	Other operations: _____	

Social History and Lifestyle:

Do you drink alcohol? YES NO If YES, How many drinks on an average day? _____

Do you currently smoke? YES NO If YES, How much do you smoke? _____

How long have you been smoking? _____ If you quit smoking, when did you quit? _____

How many packs a day did you smoke? _____ How many years did you smoke before quitting? _____

Are you on a special diet? YES NO If YES, What type if diet? _____

How many cups of caffeinated beverages do you drink on an average day? _____

Do you exercise on a regular basis? YES NO If YES, What type of exercising and how often? _____

Do you have a history of drug dependency? YES NO If YES, Specify: _____

Place of Birth: _____ Religion: _____

Education (highest level): _____ Occupation: _____ Hours Worked per Week: _____

Marital Status: Single Married Divorced Widowed Spouse Occupation: _____

Do you live: Alone With Spouse Children Other

Family History: Please list any brothers, sisters, parents, or children who have had heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells below the age of 60:

Relationship: _____ Condition: _____ Deceased: Y N

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Review of Systems:

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:

Decreased exercise tolerance? YES NO _____
 Fatigue? YES NO _____
 Weight change? Gain Loss YES NO _____
 Change in Appetite? YES NO _____

Integumentary (Skin):

Changes in moles? YES NO _____
 Rash? YES NO _____
 Itching? YES NO _____
 Changes in hair? YES NO _____
 Changes in nails? YES NO _____

Eyes:

Do you wear glasses/contact lenses? YES NO _____
 Do you have blurred vision? YES NO _____
 Do you experience double vision? YES NO _____
 Do you have a history of cataracts? YES NO _____
 Glaucoma? YES NO _____

Ear, Nose, Mouth and Throat:

Do you have a hearing deficit? YES NO _____
 Do you wear dentures/braces? YES NO _____
 Chronic sinus problems? YES NO _____
 Do you have nose bleeds? YES NO _____
 Hoarseness/Changes in voice? YES NO _____

Respiratory:

Do you wheeze? YES NO _____
 Do you have a chronic cough? YES NO _____
 Have you coughed up blood? YES NO _____
 Do you experience shortness of breath? YES NO _____
 At rest? With activity?
 Do you snore? YES NO _____

Cardiovascular:

Chest pain, pressure or tightness? YES NO _____
 At rest? With activity?
 Heart palpitations (racing)? YES NO _____
 Irregular heart beats? YES NO _____
 Short of breath lying flat? YES NO _____
 Waking up panicky, short of breath? YES NO _____
 Have you passed out? YES NO _____
 Swelling of feet or ankles? YES NO _____
 Pain in legs with walking? YES NO _____

Gastrointestinal System:

- Frequent nausea? YES NO _____
- Frequent vomiting? YES NO _____
- Abdominal pain? YES NO _____
- Black, tarry stool? YES NO _____
- Bright red blood in stool? YES NO _____
- History of stomach ulcers? YES NO _____
- Frequent diarrhea? YES NO _____
- History of gallbladder problems? YES NO _____
- History of liver problems? YES NO _____

Genitourinary:

- Do you have pain with urination? YES NO _____
- Sense of urgency to urinate? YES NO _____
- Awaken frequently to urinate? YES NO _____
- History of bladder, kidney infection? YES NO _____
- History of kidney stone? YES NO _____
- Males: Prostate problems? YES NO _____
- Females: Post menopausal? YES NO _____
- Currently taking hormone replacement? YES NO _____

Musculoskeletal:

- Chronic back pain? YES NO _____
- Arthritis? YES NO _____
- History of gout? YES NO _____
- Joint pain or stiffness YES NO _____
- Muscle pain or cramps? YES NO _____
- Muscle weakness? YES NO _____
- History of blood clots in legs? YES NO _____
- History of varicose veins? YES NO _____

Neurological:

- Temporary blurred vision/loss of vision? YES NO _____
- Temporary weakness and/or tingling involving an arm or leg? YES NO _____
- Severe headaches? YES NO _____
- Migraine headaches? YES NO _____
- Convulsions/Seizures? YES NO _____

Psychiatric:

- History of depression? YES NO _____
- Chronic Anxiety? YES NO _____
- Stress at work or home? YES NO _____
- History of drug or alcohol abuse? YES NO _____
- Trouble sleeping? YES NO _____
- Thoughts of suicide? YES NO _____

Endocrine:

- Fatigue? YES NO _____
- High cholesterol? YES NO _____
- Diabetes? YES NO _____
- Thyroid problems? YES NO _____

Hematological/Immunologic:

Chronic low blood count/anemia?

YES NO

Bleeding problems?

YES NO

Seasonal allergies?

YES NO

Food allergies?

YES NO

Thank you. Again, please be sure to bring all your medicines to each visit with us.

HCA #: _____



Financial Policy

Thank you for choosing Heart Clinic Arkansas as your health care provider. We are committed to providing excellent health care services to our patients. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

❖ **It is your responsibility to provide us with your most current insurance information.**

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that as medical providers, our relationship is with you, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We do accept Medicare assignment and participate in a number of HMOs, PPOs, and other managed care plans. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- It is unlawful to waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per the Federal False Claims Act, Federal Anti-kick Statute, and state and federal insurance fraud laws. It is also a violation of our managed care contracts. This includes services deemed as "Professional Courtesy".
- Co-payments are due at the time of service.
- A 25% "Quick Pay" discount will be given to patients that do not have insurance but are willing to pay their balance at the time of service.

❖ **It is your responsibility to provide us with your most recent billing information.**

- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balance you may owe. If you have any questions or dispute the validity of this balance it is your responsibility to contact our business office within 30-days after receipt of the initial statement.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30-days of statement issue date are deemed past due. If the entire balance cannot be paid in full, our Billing Office can arrange a payment plan with minimal monthly payments expected. **Past due accounts may be referred to a professional collection agency.** You will be responsible to pay all collection costs incurred.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance.
- Failure to keep your account balance current may require us to cancel or reschedule appointments.

If you have any questions regarding your account, please contact our Billing Office by calling 501-255-6003. If you have any questions regarding your appointment or other issues, please call 501-255-6000.

All co-payments are due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Signature of Responsible Party

Print Name

Date