

**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 of 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.

Relationship: \_\_\_\_\_ Condition: \_\_\_\_\_ at what age: \_\_\_\_\_ 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?  
 At rest?  With activity?  YES  NO \_\_\_\_\_
- Do you snore?  YES  NO \_\_\_\_\_

**Cardiovascular:**

- Chest pain, pressure or tightness?  
 At rest?  With activity?  YES  NO \_\_\_\_\_
- 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?                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Frequent vomiting?               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Abdominal pain?                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Black, tarry stool?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Bright red blood in stool?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of stomach ulcers?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Frequent diarrhea?               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of gallbladder problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of liver problems?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Genitourinary:**

- |                                       |                              |                             |       |
|---------------------------------------|------------------------------|-----------------------------|-------|
| Do you have pain with urination?      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Sense of urgency to urinate?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Awaken frequently to urinate?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of bladder, kidney infection? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of kidney stone?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Males: Prostate problems?             | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Females: Post menopausal?             | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Currently taking hormone replacement? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Musculoskeletal:**

- |                                 |                              |                             |       |
|---------------------------------|------------------------------|-----------------------------|-------|
| Chronic back pain?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Arthritis?                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of gout?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Joint pain or stiffness         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Muscle pain or cramps?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Muscle weakness?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of blood clots in legs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of varicose veins?      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Neurological:**

- |  |                              |                             |       |
|--|------------------------------|-----------------------------|-------|
| Temporary blurred vision/loss of vision?                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Temporary weakness and/or tingling<br>involving an arm or leg? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Severe headaches?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Migraine headaches?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Convulsions/Seizures?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Psychiatric:**

- |                                   |                              |                             |       |
|-----------------------------------|------------------------------|-----------------------------|-------|
| History of depression?            | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Chronic Anxiety?                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Stress at work or home?           | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of drug or alcohol abuse? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Trouble sleeping?                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Thoughts of suicide?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Endocrine:**

- |                   |                              |                             |       |
|-------------------|------------------------------|-----------------------------|-------|
| Fatigue?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| High cholesterol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Diabetes?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Thyroid problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Hematological/Immunologic:**

Chronic low blood count/anemia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Bleeding problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Seasonal allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Food allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

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



## FINANCIAL POLICY

**All Co-payments are due at check in for your appointments.**

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 part of our professional relationship, we encourage you to read our financial policy and ask that you acknowledge your understanding by signing below.

### FINANCIAL RESPONSIBILITY

The patient (or designated responsible party) has full financial responsibility for **all** charges for services provided. We gladly file insurance claims as a courtesy but this does not relieve the financial responsibility of those charges from the patient and we do not guarantee all charges are covered by the patient's insurance plan or payment will be received from the insurance carrier. **Your insurance co-pay is due at check in for your appointments.** Contact your insurance carrier if you have questions regarding your insurance coverage, deductible or co-pay. Heart Clinic Arkansas physicians are participating providers with most major insurance carriers, Medicare and Arkansas Medicaid and are required to comply with our contractual obligations. **It is unlawful to waive co-pays, deductibles or co-insurance amounts.**

### INSURANCE AND PATIENT / BILLING INFORMATION

In order to accurately and timely file an insurance claim or notify the patient regarding any insurance or medical issues, we will routinely update this information upon return visits. **It is the patient's responsibility to provide accurate insurance and patient / billing information.** Please be prepared to bring insurance card(s) to each appointment and let our staff know when there has been a change in the patient or responsible party information. **Please note- if we fail to receive payment or notice from the insurance company we have on file within 60 days of submitting the claim, the entire balance will become due from the patient.**

### OPTIONS FOR PAYMENT

We accept all major credit cards, cash or check. We also offer online bill pay through our website at [www.heartclinicarkansas.com](http://www.heartclinicarkansas.com) under Patient Information. Assistance is available for qualified individuals with financial hardship or lack of insurance coverage.

### PAYMENT PLANS AND DELINQUENT ACCOUNTS

As a courtesy to our patients, **we allow 90 days for payment of balances** after insurance has paid its portion of those charges and contractual adjustments have been made. **In some instances, a short term payment plan may be available and arranged through our Heart Clinic Arkansas Financial Consultants.** However, **as we are not a financial institution, any balance remaining will be transferred to a collection agency. Collection fees may be charged to you.** Heart Clinic Arkansas is not able to service lengthy financial arrangements and follow up on delinquent accounts. We care about our patient's financial needs and the collection agency is equipped to work with our patients on successful payment of account balances with terms extending beyond what we can offer at Heart Clinic Arkansas.

### INSUFFICIENT FUNDS

A \$30 insufficient fund charge will be added to the patient balance for any returned checks or reversed debit or credit card charges from our bank.

### HEART CLINIC ARKANSAS CONTACT INFORMATION

Contact our billing office at 501-255-6003 or for added convenience email at [billing@heartclinicarkansas.com](mailto:billing@heartclinicarkansas.com).

### ACKNOWLEDGEMENT:

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name If Not Responsible Party