New Patient Information

Demographic

Patient Name: ______________________________ DOB: ________________ Sex: ____________

Race: American Indian/ Alaska Native Asian Black/African American Hispanic/Latino Native Hawaiian/Pacific Islander White/Caucasian Preferred Language: ____________________

Mailing Address: ____________________________________ City: ____________________ State: ________

Zip Code: ____________ Home Phone: ____________________ Cell Phone: ____________________

Physical Address: ________________________ City: ________________ State: ________ Zip: _________

Email Address: _______________________________ Social Security Number: ___________________

Emergency Contact Information

Name: _______________________ Phone Number: ___________________ Relationship: __________

Physician Information

Referring Physician: ____________________________ Family Physician: _______________________

Pharmacy Information:

Preferred Pharmacy: _____________________________ Phone Number: ______________________

City: _______________________ State: _____________

Employment Information:

Employment Status: Employed Unemployed Full Time Student Child Retired

Patient Employer: ________________________________ Work Phone: ________________________

Employer Address: _______________________________________ City: __________________________

State: ______________________ Zip Code: ___________________

Insurance Information

Primary Carrier: ___________________________ Contract Number: ____________________________

Secondary Carrier: _________________________ Contract Number: ____________________________

If insurance policy holder is other than the patient: ____

Is this patient a resident of a nursing home: Yes No

Is this patient under hospice care: Yes No

____ ___________________________

Patient Signature Date

NEW PATIENT INTAKE FORM

Name: ______________________ DOB: ______________________

Main Reason for today's office visit: ______________________

Do you have a history of heart problems or heart disease?

☐ Heart Attack ☐ Stents in Heart ☐ Bypass Surgery ☐Congestive Heart Failure

Are there any family members with heart problems or heart disease? ☐ No ☐ Yes

☐ Father __________ ☐Brother __________ ☐ Mother __________ ☐Sister __________

What other medical problems do you have?

☐ Diabetes ☐ Stroke/TIA ☐High Blood Pressure ☐ High Cholesterol ☐ Other: __________

Do you smoke? ☐ No ☐Quit in __________ ☐Yes, About ______ per day ☐Other: __________

Do you drink any alcohol? ☐ No ☐Yes, describe: ______________________

Do you have any of the following problems or symptoms? ☐ All systems are normal

Constitutional

☐ Chills

☐ Fatigue

☐ Weight gain

☐ Weight loss

Head

☐ Dizziness

☐ Fainting

☐ Headaches

Eyes

☐ Blurred vision

☐Double vision

☐ Loss of Vision

Skin

☐ Easy bruising

☐ Rashes

Reproductive (Females

☐Pregnancy

☐ Birth control

Cardiovascular

☐Chest pain or discomfort

☐Shortness of breath with activity

☐Palpitation

☐Heart Murmur

☐Leg pain when walking

☐ History of Rheumatic Fever

☐ Difficulty breathing lying down

☐ Walking with shortness of breath

☐ Waking with shortness of breath

☐ Swelling of legs

Respiratory

☐ Cough

☐Wheezing

☐ Coughing up blood

☐ Shortness of breath

☐ Sputum

Gastrointestinal

☐ Abdominal Pain

☐ Nausea

☐ Diarrhea

☐Black Stool

☐ Vomiting

☐ Vomiting Blood

☐ Rectal Bleeding

Neurological

☐Weakness

☐Numbness

☐ Paralysis

☐ Stroke

☐ Tingling

☐ Unsteady gait

☐ Seizures

Musculoskeletal

☐ Arthritis

☐ Back Problems

☐ Memory Loss

Psychiatric

☐Anxiety

☐ Depression

Endocrine

☐Diabetes

☐ Thyroid problems

Hematologic

☐ Anemia

☐ Blood clots

Urinary

☐ Blood in urine

☐ Kidney Stones

NELSON S. GWINN III, MD, FACC, FSCAI
THOMAS E. YOUNG, MD, PH.D, FACC
CHRISTOPHER D. CENTAFONT, DO, FACC
ANDREAS MUENCH, MD, FACC, FSCAI

Board Certified Cardiologists

ERIN HARRELL, CRNP, NP-C
KELLI KEY-ANDERSON, CRNP, NP-C

PHILIP A. HOLLAND
Administrator

1146 ROSS CLARK CIRCLE, S.E.
DOTHAN, ALABAMA 36301
WWW.SE-CARDIOLOGY.COM

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Southeast Cardiology Clinic reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled withing a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12- month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing, you acknowledge that you have received this notice and understand this policy.

______________________________ ____________________

Printed Name Date

____

Signature

Payment Policy

1. **Insurance** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is the patient's responsibility. Please contact your insurance company with any questions you may have reagrding your coverage.
2. **Co-payments and deductibles** All co-payments must be paid at the time of service. Also, all coinsurance and deductible are due at time of service. Payment of these items is part of your contract with your insurance company. Failure on our part to pay co-payments, coinsurance, and deductibles can be considered breaking your financial agreement. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
4. **Proof of Insurance** All patients must complete our patient information form before seeing the doctor or nurse practitioner. We must obtain a copy of your drivers' license or other picture ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims Submisson** We will submit your claims to your insurance as a courtesy. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to your contract.
6. **Coverage Changes** If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment** If your account is 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this it to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis.

A. **Financial Agreement and Assigment of Insurance Benefits** The undersigned agree (s) , whether signing as agent or as patient, that in consideration of services to be rendered to patient, the undersigned is obligated to pay for some in accordance with the regular rates and terms of the clinic and that should the account be referred by the clinic to an attorney for collection, the undersigned shall pay reasonable attorneys fees, interest and all cost of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of Alabama or any other states as to personal property. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to the physician for the respective services rendered. The undersigned and/or patient agrees and understands that acceptance of insurance coverage is conditional until insurance pays and all charges not pad by insurance are the responsibility of the undersigned and/or patient. The undersigned and/or patient is responsible for the compliance with any pre-certification and/or other requirements of any insurance company or third party payor. The undersigned and/or patient is responsible for any difference not paid by insurance whether it be for type room used or the charge structure used by the insurance company or third party payor versus that of the clinic. The undersigned and/or patient may have access to billing information which may contain PHI.

B. **Authorization for Communications** By providing any telephone number and/or email address via any oral or wirten method at any time or by contacting us or our telephone contractors, assignees or agents, from any phone number or email address, you certify that the phone number(s), email address or any other information you provide for the purpose of contacting you, that you're the owner subscriber, responsible party and/or customary user and/or you have obtained authorization from the owner, subscriber, responsible party and/or customary user to provide authorization for communication via the information provided or use; further you authorize us, our clients, agents, and/or contractors to use any of all information, including telephone numbers classified as wireless, cellular, VoIP text or other messaging services including those services which may use plan minutes or incur a per call or per minute charge and also includes communication via email which may incur charges in a similar manner or via access methods for the purpose of contacting you regarding this and any prior or subsequent accounts. This authorization is also expressly conveyed to any contactor, agent, third-party, assignee, buyer, individual or others authorized by this facility and/or its providers to assist with the resolution or collection of any indebtedness to any party for any reason. This may include contact via Automated Telephone Dialing Systems (ATDS) which may utilize automated dialing, predicitve dialing and unattended messaging or dialing equipment; text messages, leaving of messages on answering machine/voice mail or similar devices or methods; and specifically includes leaving messages with individuals. These authorizations shall remain in effect unitl revoked by me. Should any section(s) of this authorization be deemed to be invalid or non-enforceable by any applicable court, all other sections of this and any authorizations shall remain in effect and enforceable.

I understand and accept responsibility for Southeast Cardiology Clinic, Inc.'s payment policy. I understand that while this consent is voluntary, if I refuse to sign this consent, Southeast Cardiology Clinic Inc. can refuse to treat me. I understand this authorization can only be revoked in writing, and if I revoke my consent, such revocation will not affect any actions that Southeast Cardiology Clinic, Inc. took before receiving my revocation.

I hereby certify that the information given in applying for payment under Title XVII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration, the State of Alabama, Georgia, or Florida or their intermediaries, carrier or agents any information needed to determine these benefits for related services.

____________________________________ ____________________________

Signature of Patient or Patient Representative Date

____

Relationship of Representative to Patient

Patient Consent Form for the Use and Disclosure of Protected Health Information

By signing this consent form, you give us permission to use and disclose protected health information about you including information that may be deemed sensitive for treatment, payment, and healthcare operations except for any restrictions specified below which we have agreed. Protected health information is individually identifiable information we create or receive, including demographics relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this consent form. As provided in our Notice, the terms of the Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting our Administrator, Philip Holland at 334-712-1929.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please request a copy of form entitled Request for Restriction on Use and Disclosure of Patient Information

If you do not sign this consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this consent form.

You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization to Release Health Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

Print Patient Name: ______________________________ Date of Birth: ____________________

Patient Signature: ________________________________ Date: ______________________

I hereby authorize Southeast Cardiology Clinic Inc. to speak to the individual(s) named below regarding my protected health information (optional):

Permission Regarding Disclosure of your Health Information

Name: ____________________________ Relationship to Patient: ________________________

Phone: _________________________________

Name: ____________________________ Relationship to Patient: ________________________

Phone: _________________________________