Abrazo™ Arizona Heart Institute

Patient Information

Acct#_____

Patient's Name (Last)_____ (First)_____ (M.I.)_____

SS#_____ Date of Birth _____/_____/_____ Marital Status_____ Sex_____

LOCAL ADDRESS

Street_____ Apt#_____

City, State, Zip_____

Phone (H)_____ (M)_____

PERMANENT/MAILING ADDRESS

Street_____ Apt#_____

City, State, Zip_____

email _____

EMERGENCY CONTACT

Name (Last)_____ (First)_____ (M.I.)_____

Phone (H)_____ (B)_____ Relationship to Patient_____

OTHER PHYSICIAN INFORMATION

Name of Referring Physician (Last)_____ (First)_____ (M.I.)_____

Name of Primary Care Physician (Last)_____ (First)_____ (M.I.)_____

PRIMARY INSURANCE

☐ HMO ☐ PPO ☐ Medicare ☐ AHCCCS

☐ Workers Comp ☐ Other_____

Insurance Name_____

Address_____

Address_____

City, State, Zip_____

Phone_____ Eff Date____/____/____

Policy/ID#_____

Group#_____

Policy Holder: Name_____

Relationship to Patient_____

(Policy Holder) DOB _____/_____/_____

SS#_____

Employer_____

Phone_____

SECONDARY INSURANCE

☐ HMO ☐ PPO ☐ Medicare ☐ AHCCCS

☐ Workers Comp ☐ Other_____

Insurance Name_____

Address_____

Address_____

City, State, Zip_____

Phone_____ Eff Date____/____/____

Policy/ID#_____

Group#_____

Policy Holder: Name_____

Relationship to Patient_____

(Policy Holder) DOB _____/_____/_____

SS#_____

Employer_____

Phone_____

Are you a resident of a: ☐ nursing home ☐ extended care facility ☐ skilled nursing facility ☐ assisted living facility?

Are you enrolled in hospice? ☐ Yes ☐ No

Patient Signature_____ Date_____

Abrazo™
Arizona Heart Institute

VHS Outpatient Clinics, Inc.
Abrazo Medical Group
PATIENT AUTHORIZATION SHEET

Name (please print):_____

Date of birth:_____

Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed: _____ Date:_____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Arizona Heart Institute. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: _____ Date:_____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: _____ Date:_____

CONSENT FOR TREATMENT: I hereby authorize the physicians, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: _____ Date:_____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?
☐ YES ☐ NO If yes, please provide a copy for our records

Abrazo™
Arizona Heart Institute

Acknowledgement of Privacy Practices

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received, been offered, or reviewed the Abrazo Arizona Heart Institute's Notice of Privacy Practices.

_____ _____

Patient Signature
Or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

If you would like any person(s) to be able to communicate with the Abrazo Arizona Heart Institute about your care, please include their name below. You may add or subtract any person at any time.

You may discuss my care with the following person(s):

Name_____

Name_____

Name_____

Name_____

Abrazo™ Arizona Heart Institute

Patient History

Date:_____ Chart #:_____ Phone:_____

Name:_____ DOB:_____ Age:_____

Address:_____

Occupation:_____ Retired: Y or N

Referring Doctor:_____ Primary Care Doctor:_____

Reason for Visit (history of present illness):_____

_____

Risk Factors

Do You Use Tobacco: ☐ Current ☐ Former ☐ Never
Type: ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ Smokeless Year Quit_____
Packs/day_____ Years used_____ Passive smoke exposure: ☐ No ☐ Yes

Diabetes: ☐ Yes ☐ No ☐ Unknown **Type:** ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset) Year diagnosed_____
HgbA1c: Last test date_____ Result_____ Target Range_____

High Cholesterol: ☐ Yes ☐ No ☐ Unknown **Type:** ☐ Cholesterol ☐ Triglycerides ☐ Cholesterol+Triglycerides ☐ Low HDL Syndrome

High Blood Pressure: ☐ Yes ☐ No ☐ Unknown Year diagnosed_____

Family History of Premature Coronary Artery Disease: ☐ Yes ☐ No ☐ Unknown ☐ Family History Unknown

Peripheral Vascular Disease: ☐ Yes ☐ No ☐ Unknown

Previous Medical History

Have you ever experienced or have been diagnosed with the following?

Congestive Heart Failure (CHF): ☐ No ☐ Yes Year diagnosed_____

Heart Attack (Myocardial Infarction): ☐ No ☐ Yes Year diagnosed_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Stroke: ☐ No ☐ Yes Year diagnosed_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Cancer: ☐ No ☐ Yes Year diagnosed_____ What type?_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Previous Medical History

Lung Disease: ☐ No ☐ Yes Year diagnosed_____
What type?_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Thyroid Disorder: ☐ No ☐ Yes Year diagnosed_____ Type: ☐ Hyperthyroid ☐ Hypothyroid
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Heart Valve Disorder: ☐ No ☐ Yes Year diagnosed_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Vascular Disorder: ☐ No ☐ Yes Year diagnosed_____
Have you had surgery related to this illness? ☐ No ☐ Yes, when_____
What procedure was performed? _____

Other Surgeries or Major Illnesses:_____

_____

Social History

In the last 3 weeks have you traveled out of the state or country?: ☐ No ☐ Yes Where_____
Have you had close contact with someone who recently traveled to West Africa and was ill? ☐ No ☐ Yes
Had close contact with bats, rodents, or primates from West Africa? ☐ No ☐ Yes
Marital Status: ☐ Annuled ☐ Divorced ☐ Interlocutory ☐ Legally separated ☐ Life partner ☐ Married
☐ Polygamous ☐ Single ☐ Unknown ☐ Widowed

Do you have children: ☐ No ☐ Yes: Number of sons:_____ Number of daughters:_____

Advanced Directives: ☐ None ☐ Do not resuscitate ☐ Refused ☐ Health care proxy
☐ Durable power of attorney ☐ Do not place on life support ☐ Living will, date:_____

Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Refused
Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Refused

Primary Language: ☐ English ☐ Spanish ☐ French Other:_____

Do you follow a specific diet such as: *(check all that apply)*
☐ 1600 calorie ☐ 1800 calorie ☐ 2000 calorie ☐ Diabetic ☐ Gluten-free ☐ Healthy ☐ High calorie ☐ High fat
☐ High roughage ☐ High salt ☐ Junk food ☐ Low fat ☐ Low residue ☐ Low salt ☐ No red meat ☐ Regular
☐ Vegan ☐ Vegetarian

Activity level: ☐ Moderate ☐ Sedentary ☐ Unable to exercise ☐ Vigorous

Exercise type:_____

Exercise frequency: ☐ 2-3 times per week ☐ 3-4 times per week ☐ Daily ☐ Never ☐ Occasional

Do you use alcohol: ☐ Current ☐ Never ☐ Former Year Quit_____ Frequency:_____

Do you drink/eat products with caffeine? ☐ No ☐ Yes
What type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Tablets ☐ Tea ☐ Other_____

Drug use/abuse? ☐ Current ☐ Never ☐ Former Year Quit_____ Frequency:_____
Route: ☐ Intramuscular ☐ Inhaled ☐ Intravenous ☐ Oral ☐ Smoked ☐ Snorted Type_____

Family Medical History

Major health problems in your family history, such as diabetes, stroke, hypertension, hyperlipidemia, thyroid disorder, sudden cardiac death.

☐ Family History Unknown

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

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Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Family Member________________________________ Health Problem____

Age at death______________ Cause of death____

Medication Information

Pharmacy Name:_____ **Phone:**_____

Address:_____ **Fax:**_____

City:_____ **State:**_____ **Zip:**_____

Current Medications and "as needed" medications:

Medication	Dosage	How often?

Vitamins and Supplements:

Vitamin/Supplement	Dosage	How often?

Are you allergic to any medications: ☐ No ☐ Yes

Medication you are allergic to:	Reaction:

Other allergies (food, adhesive tape, iodine, latex, etc.)_____

Review of Systems

Check only the problems you are currently experiencing:

Cardiac
- ☐ Chest Pain/Pressure
- ☐ Excessive perspiration
- ☐ Palpitations/Fluttering
- ☐ Loss of consciousness
- ☐ Trouble breathing at night
- ☐ Syncope

Vascular
- ☐ Leg pain/Claudication
- ☐ Swelling
- ☐ Varicose veins
- ☐ Ulcer/Leg ulcer/ Non-healing sore
- ☐ Cool extremity

Constitutional
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness

HEENT
- ☐ Vision changes
- ☐ Hearing loss
- ☐ Redness
- ☐ Burning
- ☐ Nasal congestion

Respiratory
- ☐ Snoring
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Cough
- ☐ COPD
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Reflux
- ☐ Bleeding
- ☐ Distention
- ☐ Constipation

Genitourinary
- ☐ Blood in urine
- ☐ Getting up at night to urinate
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Incontinence

Neurology
- ☐ Dizziness
- ☐ Memory loss
- ☐ Seizures
- ☐ Headache
- ☐ Weakness
- ☐ Gait disturbance
- ☐ Numbness in extremities
- ☐ Confusion
- ☐ Balance disturbance

Psychiatry
- ☐ Depression
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Nervousness
- ☐ Suicidal
- ☐ Sleep disturbances

Hematology
- ☐ Anemia
- ☐ Easy bruising
- ☐ Thrombocytopenia
- ☐ Easy bleeding

Endocrine
- ☐ Goiter
- ☐ Tremors
- ☐ Hair loss

Skin
- ☐ Rash
- ☐ Blisters
- ☐ Sores
- ☐ Irritation

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Back pain
- ☐ Muscle cramps

Immune System
- ☐ Asthma
- ☐ Eczema
- ☐ Food allergies

Physician Signature _____ Date _____

Abrazo™ Arizona Heart Institute

Notice of Privacy Practices

Notice of Privacy Practices for Abrazo Arizona Heart Institute

(referred to in this document as "the provider")

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

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The provider may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Provider has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

A. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment: Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations: We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the provider and to provide quality care to all patients. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Employee review activities.

- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities. Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.
- Business management and general administrative activities In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures: As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:
• To remind you of an appointment.
• To inform you of potential treatment alternatives or options.
• To inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required: We will disclose your protected health information when we are required to do so by any Federal, State or local law.

B. When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:
- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Abuse, Neglect Or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena in some circumstances.

III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the

circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information: You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the provider uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

B. The right to obtain a paper copy of this notice: Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The provider is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the provider changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the Privacy Contact using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be refused treatment or retaliated against in any way for filing a complaint.

Abrazo Arizona Heart Institute
ATTN: Privacy Contact
2632 North 20th Street, Phoenix, AZ 85006
Telephone: (602) 604-6104, Fax: (602) 604-5056

VIII. Effective Date - This Notice is effective April 14, 2003.
Revision Date: August 6, 2008.