DEARBORN CARDIOLOGY
Cardiac & Vascular Disease

Office Use
Account Number: _____ Date: _____

Entered by: _____

PATIENT REGISTRATION

Patient Name: _____

Street Address: _____ **City**: _____ **Zip:** _____

Patient's Social Security Number: _____ **Date of Birth**: _____

Marital Status: S M W SEP D **Sex**: M F **Race**: _____ **Ethnicity**: _____

Telephone #: Home _____ Work #_____ Cell #_____

EMAIL: _____

Please advise staff if you would like access to your records via the Patient Portal

Spouse's Name: _____ Spouse's Tel #: _____

Emergency Contact: _____ Tel# _____ Relationship: _____

Advance Directive Education

1. Do you have a will or Advanced Directive? ___ Yes ___ No

Where would you like us to call you first? ☐ Home ☐ Work ☐ Cell

Pharmacy Name: _____ Street: _____ City: _____

Mail Order Pharmacy: _____

How did you hear about us? _____ Other Doctors: _____

Primary Care Physician: _____

Would you like your chart notes and testing automatically sent to his/her office? Yes / No

Insurance Information

Primary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Subscriber Address (if different than patients): _____

ID# _____ Group# _____ Tel# _____

Secondary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Subscriber Address (if different than patients): _____

ID# _____ Group# _____ Tel# _____

Financial Policy / Insurance Authorization/Assignment of Benefits

The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures. Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement.

CO-PAY IS EXPECTED AT THE TIME OF SERVICE

You are responsible for knowing your insurance/auto/work comp benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for KNOWING your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service.** Any billed balances are due within 30 days of the statement date.

We kindly ask that you do not discuss financial situations with the physicians, there time with you is to provide quality medical care. Questions and/or financial agreements are handled by management.

Please have ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR VERIFICATION AT ALL TIMES. Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $30.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.

I request that **payment of authorized Medicare/or any third party benefits be made to or on my behalf to Elias H. Kassab M.D. PLLC,** for any services furnished to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare/Medicaid Services and its agents or any third party payer any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes 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 or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's or Representative's Signature: _____

Last 4 digits of SSN or Medicare Number: _____ Date: _____

HIPAA Consent

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.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purpose of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization is in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may want a friend or family member to discuss care with a physician(s), or staff member, take messages, and pick up prescriptions or other medically related communications.

- **Please indicate if there is a friend or family member to whom we are allowed to release medical information to:**

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

You may also identify a friend or family member to whom we are specifically <u>restricted</u> from releasing medical information to:

Name: _____ Phone _____ Relationship _____

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: 313-908-9374 This notice is effective: 2/29/12

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

_____ _____

Signature Date

Permission to Communicate my Health Information Electronically

Our office is pleased to inform that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.

_____ **YES**, I want to **participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange**. I have been informed about information that will be communicated and have had the opportunity to ask any questions that about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking the NO section and entering a revised date. If I withdraw permission any information in my electronic medication record will not be accessible by the health information exchange. At that point my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

_____ **NO**, **I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange**. I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care, especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

_____
Print First Name, Last Name, DOB

_____ _____
Signature of Patient or Representative Date

Rx History Consent

I give **permission for my provider to access my pharmacy benefits data electronically through RxHub**. This consent will enable my provider to**:** determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient or Representative Signature _____ Date _____

New Patient History Form

Patient Name: _____ Date of Birth: _____

Medications List

Medication Name (Include over the counter medication)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Past Medical History

Diabetes	____ Yes	___ No		Mental Illness	____ Yes	___ No
High Blood Pressure	____ Yes	___ No		Dementia (Alzheimer's etc.)	____ Yes	___ No
Stroke	____ Yes	___ No		Seizures	____ Yes	___ No
Heart Disease / Heart Attack	____ Yes	___ No		Cancer	____ Yes	___ No
High Cholesterol	____ Yes	___ No		• Cancer Type		
Thyroid Disease	____ Yes	___ No		Cardiomyopathy	____ Yes	___ No
(PVD) Vascular Disease	____ Yes	___ No		CHF Congestive Heart Failure	____ Yes	___ No
Bleeding Disorder	____ Yes	___ No		Atrial Fibrillation	____ Yes	___ No
Emphysema / COPD	____ Yes	___ No		Other:		
Liver Disease	____ Yes	___ No				
Rheumatic Fever	____ Yes	___ No				
Asthma	____ Yes	___ No				
Ulcers	____ Yes	___ No				

Allergies

Drug/Non-Drug Allergy	Allergic Reaction

Continuation of History

Patient Name: _____ Date of Birth: _____

Cardiac and Vascular History/Procedures

Previous Procedures	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

	Living	Age	Deceased	Age at Death	Medical History (Ex. Diabetes, Stroke, Heart Attack)
Father	☐		☐		
Mother	☐		☐		
Brother(s)	☐		☐		
Sister(s)	☐		☐		
Children	☐ **Sons #** _____		☐ **Daughters #** _____		

Patient Social History

Use of Tobacco:	___Never ___Previously, years quit? ___Current Packs/Day ____
Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency_____
Exercise:	___No ___Yes, Type/Frequency_____
Caffeine:	___No ___Yes, Type/Frequency_____