GOLDFIELD CARDIOVASCULAR INSTITUTE

(P) 480-962-0101 (F) 480-962-0202
EMAIL: FRONTOFFICE@GOLDFIELDMED.COM

NEW PATIENT DEMOGRAPHIC INFORMTAION

Name: _____ Male ☐ Female ☐

Date of Birth: _____ **Social security #:**_____-_____-_____

Mailing Address: _____ **City:**_____ **State:** _____ **Zip:**_____

Home Phone: (_____) _____ **Cell Phone** :(_____) _____

Email: _____

Permanent Mailing Address (if different from above) OR Secondary Residency

Address: _____ City:_____ State: _____ Zip: _____

****Pharmacy Name**: _____ Pharmacy Location_____

Emergency Contact

Name: _____ Relationship: _____ Date Of Birth: _____

Phone # (_____) _____ May receive protected Health Information YES ☐ NO ☐

***Primary Care Provider or Referring Physician Name:** _____

Address/Location (if known):_____

Insurance Information

Primary Insurance

Name: _____

Member ID #: _____

Group #: _____

Secondary Insurance

Name: _____

Member ID #: _____

Group# _____

Conditions for filing insurance claims: We will file your primary and secondary insurance for you as a courtesy, if insurance pays you, the patient, per your agreement with them, you will be responsible to pay Dr. Shantha Kumar once insurance has sent it to you. Please make sure that you update us with any changes to your insurance plans or change of plans as soon as possible. **MEDICARE PATIENTS**: **WE ACCEPT MEDICARE ASSIGNMENT.**

I acknowledge Goldfield Cardiovascular Institute will charge me a $35 cancellation fee for all missed appointments that are not cancelled at least 24 hours in advance.

Payment policy: Accounts are due and payable upon receipt of service; however a 30 day period will be extended for insurance reimbursement. You will be responsible for any attorney's fees incurred in any attempt to collect past due accounts. **There will be a 30% fee of the balance owed if it goes into collections.**

The authorization below must be signed before we can file any claims: I authorize the release of medical information necessary for filing health insurance claims for me by Dr. Shantha Kumar. I also authorize the insurance companies to make payment directly to this company. I agree to the payment conditions outlined above, and I understand that any overpayment will be refunded to the appropriate party. **I understand that I am financially responsible for services not covered by my insurance co. after contractual adjustments.**

Signature:_____ Date:_____

Goldfield Cardiovascular Institute

Consent for Treatment

I give my consent to Goldfield Cardiovascular Institute, to treat me medically that is in the best interest for my health. I understand that Goldfield Cardiovascular Institute will care for my medical needs within the scope of their practice and will always do what is in my best interest. Medically, I am aware that I can refuse medical treatment at any time, and if so I will not hold Goldfield Cardiovascular Institute liable for my decisions; which could cause me danger medically or even harm my life. This authorization is valid for as long as I am a continued patient at Goldfield Cardiovascular Institute._____ (Initial)

Consent for Prescription (Rx) Review/Refills

I give Goldfield Cardiovascular Institute authorization to review all Rx history pertaining to my medical health and treatment. I understand that the provider will need to review my prescriptions to make the best decision for my continued care and well-being. I understand I may revoke any of these authorizations at any time, if I choose to do so it must be in written form and presented to the Office Manager. Upon completion of authorization revocation I understand that I will no longer be able to get my prescriptions filled or refilled by the Goldfield Cardiovascular Institute providers or their employees. This authorization is valid for as long as I am a continued patient at Goldfield Cardiovascular Institute.

I understand the authorizing to disclose this health information is voluntary. I can refuse to sign this authorization and do not need to sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand there is risk involved and a potential for unauthorized re-disclosure and my information may not be protected by federal confidentiality rules. If I have questions about disclosure of my information I can contact Goldfield Cardiovascular Institute for more information._____ (Initial)

Financial Agreement

Thank you for choosing Goldfield Cardiovascular Institute to serve your medical needs. Our goal is to build a successful physician patient relationship with you. Your understanding of our patient financial policy and your responsibility for payment for services is important to our professional relationship. If you have any questions about our fees our policies, or your responsibility, please ask. It is your responsibility to notify our office of any changes in your address, name, telephone numbers, insurance information, etc.

Insurance claims: the physician's service is provided directly to you and not your insurance company. Insurance is a contract between you and your insurance. We will bill your primary, secondary, and tertiary insurance for you as long as you have given all the information and cards to us at the time of service, and you have assigned benefits allowing the insurance company to pay the provider directly. We will do this as a courtesy for you. Patients who are visiting or part-time residents of Arizona but live outside the United States will be responsible for charges under the self-pay price at time of service and will be given appropriate forms to send to their insurance for reimbursement.

We collect copays and deductibles at each visit. Please make sure you bring a form of payments (ex: credit card, debit card, cash) we do not accept checks for copay and deductibles, but we will accept checks for balances owed. I understand that I will be charged a $35 fee for not cancelling my appointment at least 24 hours in advance.

Any charges incurred with bad check writing will be added to the patient's balance along with a processing fee, administration fee, and bank fee. **If your account is over 90 days delinquent, you will be charged an additional 30% collection proceedings.**

_____ (Initial)

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed a how you get access to this information. Please review it carefully. **OUR COMMITMENT REGARDING YOUR PERSONAL HEALTH INFORMATION: If you would like a full detailed copy of the HIPAA privacy rules please ask and we will print one out for you.** Goldfield Cardiovascular Institute is committed to maintain and protecting the confidentiality of our patient's personal information. This notice of privacy practices applies to Goldfield Cardiovascular Institute and its employees covered by the privacy regulations required by federal and state law to protect the privacy of your individually indefinable health information and other personal information. We are required to provide you with the notice about our policies, safeguards

FOR ALL NOTICES OF CONSENT ABOVE

Signature of Authorized Person/Individual:_____

Date: _____

Relationship to Patient: _____Phone_____

GOLDFIELD
CARDIOVASCULAR
INSTITUTE

DR. SHANTHA KUMAR MD FACC/GARY GAWELKO PA-C
(P) 480-962-0101 (F) 480-962-0202
EMAIL: FRONTOFFICE@GOLDFIELDMED.COM

99 S GOLD DR SUITE 5
APACHE JUNCTION, AZ 85120

7615 E BASELINE RD
MESA, AZ 85209

6788 S KINGS RANCH RD SUITE 1
GOLD CANYON, AZ 85118

Clinic Cancellation and No-Show Policy

As posted effective October 1, 2018 a 24-hour notification is required for all cancelled and rescheduled appointments. Cancellation/rescheduling an appointment less than 24 hours prior, or not showing up for the appointment will possibly be subject to a fee of $35.00 per appointment. NOTE: If you have multiple studies on one day you will be charged the fee per study. Clinic policy states that you will be withdrawn from the practice for 3 missed appointments.

A notice letter will be sent after 2 missed appointments.

Signature: _____ Date:_____

Print Name: _____ Relationship:_____

The signature above acknowledges understanding and receipt of the cancellation/no show policies.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ DOB: _____

Mailing Address: _____

Phone # _____ Social Security #_____

Above listed patient, authorizes the following healthcare facility to make record disclosure:

Facility Name_____

Facility Phone # _____ Facility Fax #_____

Dates and type of information to disclose:

____2 years prior from last date seen

____ Dates/Other: _____

____ Specific Information Requested: _____

Purpose of disclosure is:

____Change of Insurance or Provider

____Continuation of Care

____ Referral ____ Other _____

Restrictions: Only Medical records originated through this facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, (AIDS) or (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

This information may be disclosed and used by the following individual or organizations:

Release to: _____

Address: _____

City, State, Zip: _____

Fax #_____ Phone # _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the HIM department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not otherwise revolve this authorization. The authorization will expire 90 days from date signed.

I have read the above foregoing authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Authorized Person. **X**_____ Date _____

Relationship/Capacity to Patient _____ Phone # _____

Witness Signature _____Date_____

Goldfield Cardiovascular Institute
Past/Current Medical History Form

Medical History: please check any of the conditions that represent a **SIGNIFICANT** problem with you

General		**Cardiovascular**		**Genitourinary**	
Fever or chills		Chest pain with activity		Burning or painful urination	
Recent weight change		Heart skips beats		Frequent urination	
Heat or cold intolerance		Passing out spells		Blood in urine	
Heart& Neck		High blood pressure		Bladder infection	
Swelling in neck		Heart murmur		Incontinence	
Prolonged hoarseness		Bad heart valve		Kidney stones	
Sore throat		Rheumatic fever		Change in stream	
Pain or stiffness in neck		Feet or ankle swelling		Irregular menses	
Skin		Short of breath at rest		**Gastrointestinal**	
Rash, dryness, itching		Short of breath with exercise		Rectal bleeding	
Change in nail or skin color		Short of breath lying down		Blood in stool	
Bleeding, burning tendencies		**Lungs**		Loss of appetite	
Eyes		Cough		Heartburn	
Glasses or contacts		Cough with sputum or blood		Chronic ab pain	
Double or failing vision		Wheezing		Chronic constipation	
Dry eyes		**Musculoskeletal**		Black stools	
Pain or light sensitivity		Swollen and red joint		Frequent diarrhea	
Ear, nose, mouth		Arm and leg weakness		Difficult swallowing	
Loss of smell		Leg cramp		Nausea or vomiting	
Nose bleeds		Difficulty in walking		Vomiting blood	
Sinus problems		**Neurologic**		**Endocrine**	
Runny nose		Sleep disorders		Night sweats	
Postnasal drip		Light headed or dizziness		Excessive thirst	
Earache or drainage		Speech disturbances		**Psychiatric**	
Hearing loss		Convulsions or seizures		Depression	
Ringing in ears		Numbness or tingling		Anxiety	
Dentures		Frequent headaches		Nervous breakdown	
Sores in mouth		Memory loss		Alcohol problems	
		Paralysis or weakness		Abuse physical or other type	
				Drug problems	

Past and Family History: please check all that you or family has ever had any of the following.

F= Father **M**= Mother **S**= Sibling **C**= Child

	You	**Family**		**You**	**Family**		**You**	**Family**
Hypertension			Irritable bowel			Rheumatoid arthritis		
Heart disease			Jaundice			Thyroid disease		
Stomach ulcers			Blood clots			Rheumatic fever		
Seizure/ epilepsy			Depression			Liver disease		
Diabetes			Tuberculosis			Breathing problems		
Cancer			Blood disorders			Vision problem		
Renal disease			Lupus			Hearing problems		
Ulcerative colitis			Stroke			Glaucoma		

Patient Name: _____ DOB: _____

Medication:

(If you need additional space please bring a list with information listed, to your appointment)

Name of medication	Dosage	# of Times per day	Reason for Medication

Allergies:

Please list all allergies, including medications/drugs, food, and environmental

Allergy	Reaction

Hospitalizations and surgeries:

Please list any recent hospitalizations and surgeries

Date	Reason for Hospitalization or Surgery

Chief complaint/ Reason for visit today:

_____

_____

Your current symptoms:

_____

How can we help you today?

_____

Patient Name: _____ DOB: _____

Goldfield Cardiovascular Institute

Race: **Ethnicity:** **Preferred Language**:

- American Indian or Alaska Native ☐
- Asian ☐
- Native Hawaiian or Other Pacific Islander ☐
- Black or African American ☐
- White ☐
- Hispanic ☐
- Other Race ☐
- Other Pacific Islander ☐
- Refused to Report ☐

- Hispanic or Latino ☐
- Other ☐
- Refuse to Report ☐

- English ☐
- Spanish ☐
- Other ☐

Social History

Marital status: single divorced married widow/widower other

Do you smoke? Yes No If yes, how many packs per day? _____

Did you smoke? Yes No If yes, when did you quit? _____

Do you live with a smoker? Yes No

Do you use e-cigarettes/vape? Yes No If yes, for how long?_____

Do you drink alcohol? Yes No If yes, what type & how often? _____

Do you drink caffeine? Yes No If yes, what type & how often? _____

Do you have Advance Directive/Living Will? Yes No

Would you like to learn about it? Yes No

Are you currently taking prescription or over the counter pain medications Yes/No

Recreational Drug Use:

Marijuana	Current/Past
Stimulants	Current/Past
Inhalants	Current/Past
Methamphetamine	Current/Past
Iv Drug Use	Current/Past

PREVENTATIVE

Pap smear in the past year	Yes	No
Mammogram in the past year	Yes	No
Bone Density Scan in the past 2 years	Yes	No
Colonoscopy in the past 5 years	Yes	No

Current occupation/employer:_____

Phone: (_____)_____-_____

Who lives with you at home? _____

May we contact the person listed above in case of an emergency? Yes No

Phone: (_____)_____-_____

Recent vaccinations: (circle yes or no)

Pneumovax:	Yes	No	Date: _____
HPV:	Yes	No	Date:_____
Shingles:	Yes	No	Date:_____
Tetanus:	Yes	No	Date: _____
Influenza:	Yes	No	Date: _____
Hepatitis:	Yes	No	Date:_____

Other:_____Date:_____

Patient Name: _____ DOB: _____

NAME: _____.

PATIENT SELF-ASSESSMENT

Patient Self-Assessment

Please take this self-assessment to see if you might be a candidate for additional screening for potential varicose veins and / or chronic venous insufficiency.

History

Have you ever had varicose veins? **O Yes** **O No**

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Do you experience leg pain, aching or cramping? **O Yes** **O No**

Do you experience leg or ankle swelling, especially at the end of the day? **O Yes** **O No**

Do you feel "heaviness" in your legs? **O Yes** **O No**

Do you have skin discoloration or texture changes? **O Yes** **O No**

Do you have open wounds or sores? **O Yes** **O No**

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with venous reflux disease or chronic venous insufficiency? **O Yes** **O No**

Have you had any treatments of procedures for vein problems? **O Yes** **O No**

Do you stand for long periods of time, such as at work? **O Yes** **O No**

Self-Assessment Results

If you answered yes to one or more of the above questions, please contact us for a consultation to see if you may be a candidate for venous reflux disease.