CAMP LOWELL CARDIOLOGY

WELCOME! Please fill out the information below and on the reverse side.

Today's Date _____

Patient's Name_____ Birth Date ___/___/___ Referring Dr._____

Reason for today's visit_____

Location of pain_____ Duration of pain _____

(Where is the pain problem?) *(How long have you had this problem and when did it start?)*

Past Medical History

Have you EVER had the following: (Check "**No**" or "**Yes**". Leave blank if uncertain.)

	Yes	No		Yes	No		Yes	No
Measles			Bladder Infections			Hemorrhoids		
Mumps			Epilepsy			Asthma		
Chickenpox			Migraine Headaches			Hives or Eczema		
Whooping Cough			Tuberculosis			AIDS or HIV		
Scarlet Fever			Diabetes			Infectious Mono		
Diphtheria			Cancer			Bronchitis		
Smallpox			Polio			Mitral Valve Prolapse		
Pneumonia			Glaucoma			Stroke		
Rheumatic Fever			Hernia			Hepatitis		
Heart Disease			Blood/Plasma Transfusions			Ulcers		
Arthritis			Back Trouble			Kidney Disease		
Venereal Disease			High Blood Pressure			Thyroid Disease		
Anemia			Low Blood Pressure			Bleeding Tendency		

Review of Cardiovascular System (please circle the following):

Heart trouble……yes no Chest pain or angina pectoris…..yes no Shortness of breath when walking… yes no

Palpitations……yes no Swelling of feet, ankles or hands…. yes no Shortness of breath at rest…… yes no

Date of last chest x-ray:_____

List any other medical problems:_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____

_____

_____

Medication Allergies

_____

Medications, including over the counter:_____

_____

_____

_____

_____

Preferred Pharmacy: _____ **Ph#** _____

***Patient Social History* (please circle below)**

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, Quit Date_____		Current, Packs/Day_____	
Use of Drugs:	Never	Current, Type and Frequency_____			
Excessive exposure at home or work to:	Fumes	Solvents	Air-borne Particles	Noise	Animals
	Dust				

Family Medical History

	Age	Diseases	If Deceased, cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent, or Guardian_____ Date_____

Provider's Review:

Provider's Signature:_____Date_____

CAMP LOWELL CARDIOLOGY

Mark C. Goldberg, MD
Jessica F. Hoffman, ANP-C
Martha J. Gilliam, ANP-BC
Rachel Doerr, FNP-BC
4790 East Camp Lowell Drive, Tucson, AZ 85712
Tel: (520) 319-5922
Fax 520.319.6128

Date: _____ Patient Name: _____ DOB: _____

SS#:_____ Marital Status: S M W D Sex: M F

Telephone: (H) _____ (W) _____ (C) _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

E-mail Address: _____ Employer: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

Tertiary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

I authorize the release of any medical information necessary to process any insurance claims. I permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits to Camp Lowell Cardiology for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductions, co-payments and co-insurance amounts.

My signature below attests to the accuracy and completeness of the information provided on this page; it also indicates my full understanding of the above information.

_____ _____
Patient Signature Date

CAMP LOWELL CARDIOLOGY
MARK C. GOLDBERG, MD, FACC

4790 East Camp Lowell Drive ● Tucson, AZ 85712 ● 520.319.5922

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Payment Responsibility. Since you are the individual seeking our medical services, you are responsible for payment of all charges associated with your visit. We accept cash, check, Visa or MasterCard as payments.

Missed Appointments. All scheduled appointments are necessary for you to keep whenever possible. If you do not appear for your appointment, your health may be at risk. In fairness to other patients and to the medical providers, we require at least 24 hours notice to cancel appointments. We reserve the right to charge a $25 fee for missed appointments.

Co-Payments. All co-payments are due at the time you arrive for your appointment. By law, no treatment will be provided without a co-payment when one is due.

Insurance Claims. Our office is automated to submit claims electronically to a number of insurance carriers, and we bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral or prior authorization, it is your responsibility to ensure that one is available to our office prior to or at the time of your service. Our office contracts with many insurance carriers. Please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. All coinsurance amounts or deductibles not covered by an insurance plan are the financial responsibility of the patient and are due within 30 days. If your insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Collection of Fees. All patient balances are due and payable upon receipt of the billing statement. Delinquent accounts may be referred to a collection agency. In such cases, all associated collection fees as well as past due amounts are the responsibility of the patient.

Rebilling Fee. A rebilling fee of $10 per month may be charged on all open accounts over 30 days old, including accounts on a Payment Plan.

Payment Plan. A payment plan is available if the cost for your treatment, or your balance, exceeds $200. A down payment of 30% is due at the time of your visit. A minimum payment of $30 per month is due by the 15th of each month following the month of your visit until the account balance is cleared.

Returned Checks. A fee of $50 will be charged for each returned check.

Assignment of Insurance Benefits (Patients with insurance please read and sign below.)
I hereby assign all medical and/or surgical benefits to Camp Lowell Cardiology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by my insurance. I understand that I am ultimately responsible for my own health care and follow-up appointments are important to my healthcare. I understand that I must assume the health consequences of missed follow-up care. I hereby authorize Camp Lowell Cardiology to release all information necessary to secure payment. I have read, understand, and agree to the above financial and health care policy for payment of professional fees. I understand that I, as the patient, am ultimately responsible for payment of all professional fees.

_____

Signature Printed Name Date

CAMP LOWELL CARDIOLOGY

Mark C. Goldberg, M.D. F.A.C.C.
Jessica Hoffman, ANP-C
Marti Gilliam, ANP-BC

4790 East Camp Lowell Drive
Tucson, AZ 85712-1275
Tel. 520.319.5922
FAX 520.319.6128

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before making a significant change in our privacy practice, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use/disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for use in seeking payment or for general healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights sections of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person involved with your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to protect your health information to the very best of our ability.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies and we will use that format unless we cannot practicably do so. You may make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for the copies, the staff time to locate and copy your health information, and the postage if you want the copies mailed to you. If you require an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last six (6) years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, a fee may be charged.

Restriction: You have the right to request that we place additional restrictions on our use/disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation about how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or if you have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint against us or with the U.S. Department of Health and Human Services.

Contact Information: Privacy Officer, Camp Lowell Cardiology / Tel. (520) 319-5922

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Print name)

_____ / _____
(Signature) (Date)

(For Office Use Only) We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____An emergency situation prohibition
_____Communications barriers prohibition
_____Other: _____

CAMP LOWELL CARDIOLOGY

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Fax: (520) 319-6128

Thank you for scheduling your appointment with us. We look forward to seeing you in our office.

Please arrive at least 15 minutes prior to your appointment and remember to bring along the attached forms filled out.
You must bring your picture ID, insurance cards, and a list of your current medications.

We are located in the *Village Offices* complex