IMS Cardiology

MRN ______________

Personal Information:

Patient First Name: ______________________ Initial: _____ Last Name: __________________________

Address: ____

City: ___________________________________ State: __________________ Zip Code: ______________

Primary Phone: (_____) ______________________ Secondary Phone: (_____) ______________________

DOB: ________/________/_________ SS# _____-____-_____ Email: _____________________________

Race:	**Ethnicity:**	**Gender:**	**Marital:**	**Language:**
White	Hispanic/Latino	Female	Single	English
Asian	Non-Hispanic/Latino	Male	Married	Spanish
American Indian/Alaskan Native	Declined		Widowed	Other: ______
Black/African American	Unknown		Divorced	
Unknown				
Declined				

Primary Care Physician: __________________________

Referring Provider: ______________________________

Reason for Visit: ____ Date Started:______________

Were you seen in Hospital or Urgent Care: YES NO If yes, where? _____________________

Insurance Information

Primary Insurance: _________________________________ Address: ____________________________

Policy #: ______________________________________ Group #: __________________________________

Policy Holder Name: _________________________ DOB: ______________ Relationship: ______________

Secondary Insurance: ________________________________ Address: ______________________________

Policy #: _____________________________________ Group #: ___________________________________

Policy Holder Name: ________________________ DOB: ______________ Relationship: _______________

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Medical History

Problems	Past	Current	Problems	Past	Current
Anemia			Heart Disease		
Arthritis			Hepatitis		
Asthma			Hernia		
Birth Defect			HIV/AIDS		
Urinary			Hypertension		
Bleeding Disorder			Irritable Bowel		
Broken Bones			Kidney Disease		
Cancer			Lupus		
Chest Pain			Lyme Disease		
Colitis			Prostate		
COPD			Seizures		
Depression			Skin Disorder		
Diabetes			Sleep Disorder		
Emphysema			Stomach Ulcer		
Fibromyalgia			Stroke		
Goiter			TB		
Headache			Thyroid Disease		
Hearing Impaired			Valley Fever		
Heart Attack			Gain/Loss		

Family History

Problem	Father	Mother	Grandparent
Alzheimer's			
Arthritis			
Asthma			
Bleeding Disorder			
Cancer			
COPD			
Depression			
Diabetes			
Epilepsy			
Genetic/Birth Disorder			
GI Disorder			
Heart Attack			
Hypertension			
Kidney Disease			
Migraine			
Seizure			
Stroke			

Surgical History

Surgery	Year	Surgery	Year
Appendix Removal		Hernia Repair	
Bone Repair		Hip Surgery	
Breast Biopsy		Hysterectomy	
Cataract Surgery		Prostate Removal	
Colon/Partial Colon		Skin Graft	
Colectomy (Removal)		Spleen Removal	
Dilation & Curettage		Other	
Fistula Insertion			
Foot Surgery			
Gall Bladder Removal			
Tonsillectomy			
Wound Debridement			
Heart Valve Replacement			

Social History

Alcohol Use	Frequent		Social		Never	
Tobacco Use	Frequent		Former		Never	
Type	Cigarettes		Smokeless Tobacco		Other	
Caffeine Use	Frequent		Social		Never	

Preferred Pharmacies

Pharmacy Name: ________________________________ Phone: _____________________________
Address: ______________________ City___________________ State ________ Zip ____________

Mail Order Name: __________________________________ Phone: __________________________
Address: ________________________ City_______________ State _______ Zip _______________

Medication List

	Medication Name	Dosage	Daily Quantity
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Allergies

Known Drug/Medication Allergies**:** ____

Known Food/Pet Allergies: ____

IMS Cardiology MRN ____________

Authorization to Request and Disclose Health Information

I authorize IMS Cardiology to disclose and request the indicated information from my records:

Patient Name: ____________________________ DOB: _____________________

Information requested to/from the Primary Care Doctor or Hospital for:

Consult Notes Radiology Reports
Lab Reports Hospital Summary

	Physician Name	Facility Name	Phone Number	Address
1				
2				
3				
4				
5				

Purpose of Requesting Medical Care

I understand:

Unless otherwise revoked in writing, this Authorization will automatically expire one (1) year from the date of my signature below.

I release IMS as well as its agents and employees from any liability in connection with the use or disclosure of the Protected Health Information covered by this Authorization.

Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from re-disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I have the right to inspect the health information to be released, and I may refuse to sign this authorization.

By signing this release form, unless otherwise specified on this form, you are agreeing to release information regarding, but not limited to: Above Information.
I may revoke this Authorization at any time by submitting a written request. Any request for revocation will not apply to information already used or disclosed pursuant to this authorization.

X_______________________________________ ______________________________
Patient Signature Date

Cancellation/No Show Policy

To promote efficient access to our practice, we require that any appointment that is no longer needed or unable to be kept must be cancelled at least 24 hours in advance.
I understand if I know no show for three (3) appointments or cancel for a total of four (4) appointments, IMS Cardiology reserves the right to discharge myself from the practice. I understand this policy is in effect for all appointments within the practice.

I understand that IMS Cardiology reserves the right to modify any policies with notice.

I have read and understand the above information, and I agree to the terms described.

X_____________________________ ___________________________
Patient Signature Today's Date

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 1-888-787-9845 or by mail at 9250 N. 3rd Street, Suite 4010, Phoenix, Arizona 85020.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Effective Date: September 23, 2013

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: ________________________________ DOB: ___________________________

Signature: ___________________________________ Date: ___________________________

RELEASE OF INFORMATION

I _____________________________________ hereby authorize IMS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: ____________________ Relationship: _________________ Phone Number: ________________

Name: ____________________ Relationship: _________________ Phone Number: ________________

Name: ____________________ Relationship: _________________ Phone Number: ________________

I authorize IMS to contact me at:
Home Phone: __________________________ Work Phone: ___________________________

May we leave a message on machine? Yes _____ No _____

Cell Phone: ___________________________ Alternate Phone: _________________________

______________________ ______________________
Patient Signature Date

______________________________ _______________________
Witness (Staff) Date

Patient Financial Responsibility Agreement

Patient Name: **Date of Birth**: **Account #**:

We at Integrated Medical Services, Inc. ("IMS") are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: We will do our best to ensure we have a valid referral for services on file. However, if your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a $25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before they are to be seen in our office. Failure to cancel an appointment in a timely manner will result in a No Show fee of $25.00. Multiple No Shows may result in the patient being discharged from IMS.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Finance fees of $5 will accrue each time a new statement is generated after the first statement was sent out and partial or no payment have been made. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact the IMS billing office at **(602) 633-3838**.

I have read the above financial policies of IMS and agree to be bound by its terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient or Responsible Party:________________________________ Date: ____________________________

Printed Name of Patient: ____

Printed Name of Responsible Party: _____________________________________ Relation to Patient: __________________

Contact Phone Number of Responsible Party: ____