Heart and Vascular Care, Inc.
3970 Deputy Bill Cantrell Memorial Road, Suite 100, Cumming, GA 30040
Phone: 678•513-CARE (2273) • Fax: 678-513-8869 • www.hvcmd.com

Clinical Cardiology • Cardiac Imaging • Diagnostic Catheterization • Interventional Cardiology • Peripheral Vascular • Pacemaker Services • Electrophysiology

PATIENT EVALUATION (PLEASE ANSWER ALL QUESTIONS)

Date: _____ **Name:** _____

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

Reason for Visit: _____

PAST MEDICAL HISTORY (check all that apply)

O Coronary Artery Disease O High Cholesterol O Thyroid Disorders O Myocardial Infraction (Heart Attack)
O Stroke/TIA O COPD/Lung Disease O Sleep Apnea O Asthma/Allergies O Auto-immune Disorders
O Hypertension (High Blood Pressure) O Anemia O Diabetes Mellitus O Heart Burn/Peptic Ulcers/Reflux
O Bleeding Disorders O DVT O Pulmonary Embolism OPVD O Kidney Disease
O Arthritis O Lumbar Spine/ Disk Degeneration O Cancer O HIV/AIDs O Hepatitis
O Other_____

Have you been vaccinated for COVID-19? O Yes O No

List all Surgeries: _____

_____

_____

List all Allergies: _____

_____

_____

LIST ALL MEDICATIONS AND DOSAGE:
(Including aspirin and over the counter medications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy: _____

Address: _____

Phone: _____ **Fax:** _____

FAMILY HISTORY (Check all that apply)

	Heart Disease	High Blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father:										
Mother:										
Brother:										
Sister:										

SOCIAL HISTORY/RISK FACTORS

Smoker: O Yes Pack(s) per day Former smoker: O Yes O No _____Year(s) quit

Alcohol: O Yes O No ~~Amount~~, if applicable: _____

Caffeine: O Yes O No Amount, if applicable: _____

Exercise: O Yes O No How often: _____

Smokeless Tobacco: O Yes O No

O No

Review of Systems:	Please check all that apply:	Acute (New Problem)	Chronic (Existing Problem)
GENERAL	FEVER		
	UNEXPLAINED WEIGHT LOSS		
CARDIOVASCULAR	CHEST DISCOMFORT		
	SHORTNESS OF BREATH		
	PALPITATIONS		
	EDEMA (SWELLING)		
	PAIN IN ARMS/LEGS		
RESPIRATORY	SNORING		
	COUGHING		
	WHEEZING		
GASTROINTESTIONAL	NAUSEA		
	HEARTBURN		
	BLOOD IN STOOL		
GENITOURINARY	BLOOD IN URINE		
	PAIN WITH URINATION		
MUSCULOSKELETAL	JOINT PAIN		
	MUSCLE PAIN		
NEUROLOGICAL	NUMBNESS/TINGLING		
	POOR BALANCE		
PSYCHOLOGICAL	ANXIETY		
	DEPRESSION		

ANNUAL CONSENT/AUTHORIZATIONS

Patient Name:_____ Date of Birth:_____/_____/_____

Consent for Treatment: I consent to the rendering of medical treatment or services as considered necessary and appropriate by the physician, physician assistant, nurse practitioner or designated staff. The consent to receive medical treatment or services includes but is not limited to initial evaluations, assessment evaluations, electrocardiogram, laboratory services or procedures, medications, patient education, and other services in which the patient will receive. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to echocardiograms, carotid ultrasounds, exercise treadmill test, nuclear stress test, PET scans, vascular and arterial ultrasounds, event monitors and other services recommended by your physician. I am aware that there may be material risks associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information. I understand I have the right to see a physician if I so choose and have the right to see a physician prior to any prescription drug or device order being carried out by the physician assistant or nurse practitioner. _____**(Initials)**

ADVANCE DIRECTIVES/EMERGENCY MEASURES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life-threatening emergency. Heart and Vascular Care will honor Advanced Directives only if they have been provided by the patient. I consent to emergency transfer to the nearest emergency facility in case of the need for emergency hospital care. A copy of the Advance Directive may be placed on the chart if the patient desires and forwarded to the hospital in the event of a transfer, information regarding Advance Directives is made available upon the patient's request. The admitting facility is not affiliated or in partnership with Heart and Vascular Care. _____ **(Initials)**

I give my consent to have the Heart and Vascular Care group obtain my prescription history from external sources. I consent to the above statements:_____**(Initials)**

CONSENT TO RELEASE INFORMATION TO A SPOUSE. FAMILY MEMBER OR SIGNIFICANT OTHER

I hereby authorize Heart and Vascular Care group to release and/or disclose any information contained in my medical record to the person(s) listed:
Name:_____Relationship to patient:_____

I hereby authorize Heart and Vascular Care group to release and/or disclose any financial information to the person(s) listed:
Name:_____Relationship to patient:_____

o I do **NOT** authorize any information to be released to anyone other than myself.

I give permission for you to provide medical and appointment information for me via the following source(s):

Phone	**Text**	**Portal/Email**
O Yes O No	O Yes O No	O Yes O No

Signature of Patient/Legal Guardian_____Date:_____/_____/_____

Patients Employer:_____ Phone:_____

lnsured's Employer:_____ Phone:_____

Heart and Vascular Care
HVCMD.com
Ph: 678-513-2273
Fax: 678-513-8869

ASSIGNMENT OF BENEFITS

I,_____,the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my authorized representative, **Heart and Vascular Care, Inc.** (the "Provider"), the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, Heart and Vascular Care, Inc. and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation slating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments, co-insurance, and deductibles at no more than my in-network cost share rate and that rate is based on my claim being processed in full compliance of governing claims handling compliance laws. I understand, agree, and hereby certify that I am obligated to pay, as charged, and billed for global service charges, regardless of if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: *"The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,"* and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative, and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health plan or ins.

I hereby designate, authorize and appoint the Provider, Heart and Vascular Care, Inc., its attorneys or other designated business associate as my authorized representative, and as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies, and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization includes all entitled benefit payments, rights, and remedies due under my governing Health and Welfare Plan or policy, to include all benefits entitled for all services rendered and ordered by my treating physician. This authorization will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I authorize Provider or Heart and Vascular Care, Inc., its attorneys, or designated business associates to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, take legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys, or designated business associates in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; **(1)** obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain any claim, appeal, or external review information; to receive any notice in connection with my claim, appeal, or external review; wholly in my stead. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

_____ _____ _____

Patient/Guardian/Insured Signature | Employer Group Name Covering Benefits | Date

FINANCIAL POLICY

- It is the policy of HVC that we provide patients with as much information as is available related to the cost of care to facilitate informed decisions. We educate patients about their benefits prior to services being provided and offer the option for patients to ask questions or contact their carrier if they do not agree with the information provided.
- Patients are financially responsible for all charges not paid by insurance. Patients are expected to pay in full at time of service, for all services rendered, unless prior arrangements are made.
- If the patient deductible has not been met at the time of service, the patient will be asked to pay the allowable fee for the service up to the amount of the estimated remaining deductible. Once insurance has been billed, any remaining balance is the patient's responsibility.
- **Patients are responsible for the entire cost of visit if they do not have insurance or choose not to file insurance. Self-pay patients will be expected to pay the expected fee for a self-pay visit at check in and any additional charges at the end of the visit upon checking out.** Payment in full is expected on the date of service unless other arrangements are made. There may be situations where the physician has not yet documented, by the time of checkout, the services provided to the patient. If this happens, the practice will bill the patient for any outstanding or remaining charges.
- Some patients will be required by their insurance carrier to obtain a "referral" from their Primary Care Physician authorizing their visit to Heart and Vascular Care, Inc. It is the patient's responsibility to obtain this referral and to be sure that the referral is communicated to Heart and Vascular Care, Inc. before the patient's visit. The staff of HVC will assist with this to the extent possible.
- A patient presenting at Heart and Vascular Care, Inc. without a required referral will be asked to sign a waiver by which he/she agrees to pay all charges generated by the visit, if a referral is not obtained to cover the visit. The patient will also be expected to pay the self-pay fee at check in for their office visit and any additional charges at the end of their visit. If a referral is received for the visit, and if the insurance pays, a refund will be sent to the patient reflecting the insurance payment.
- Patients who are experiencing difficulty in making payments on open accounts are asked to contact an HVC Patient Account Representative at (470) 533-0037 to establish a fair and appropriate payment plan. Patients may be asked, in some circumstances, to provide financial income information, which HVC can use in determining an appropriate and fair monthly payment.
- Patients with open balances on previous office visits or surgical procedures will also be asked to pay a minimum of 25% of any open balances at the time of the new visit and establish and plan to pay the balance in full. Patients who are unable to pay the 25% on any open balances may be asked to reschedule their visit.
- Patient accounts which have not been paid by the patient and/or insurance for 90 or more days since the office visit may be referred to a collection agency or attorney for collection. The patient agrees to pay costs, which could include reasonable attorney fees, court filing fees or other reasonable costs of collection efforts, in addition to the account balance. Should collection proceedings or other legal action become necessary to collect an overdue account, Heart and Vascular Care, Inc. has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.
- There will be a $35 fee assessed to your account for any check returned to our bank as unable to process for any reason. **These charges are the responsibility of the patient and will not be submitted to any insurance carrier.**

Patient Name:_____ Date of Birth: _____

Patient Signature:_____ Date: _____

PATIENT RIGHTS

1. Patients are treated with respect, consideration, and dignity.
2. Full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
3. To have considerate and respectful care, provided in a safe environment.
4. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may use an appointed representative.
5. Have a family member or representative of his/her choice be involved in his/her care.
6. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
7. Remain free from seclusion or restraints of any form that are not medically necessary.
8. Coordinate his/her care with physicians and healthcare providers they will see; patients have the right to change their provider if other qualified providers are available.
9. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment, or non-treatment and the risks involved.
11. Given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
12. Be informed by physician or designee to the continuing healthcare requirements after discharge.
13. Confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law.
14. Access information to his/her medical record within a reasonable time frame (48 hours).
15. May leave the facility even against medical advice.
16. Informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
17. Examine and receive an explanation of the bill regardless of source of payment.
18. Exercise these rights without regard to race, sex, cultural, educational, or religious background of the source of payment for care.
19. Informed regarding patient conduct and responsibilities, services available at the facility, provisions for after-hours and emergency care, fees for services, payment policies, rights to refuse participation in experimental research, advance directives will be accepted at the facility, charges for services not covered by third-party payers, and credentials of health care professionals.

** ALL FACILITY PERSONNEL PERFORMING PATIENT CARE ACTIVITIES SHALL OBSERVE THESE ABOVE RIGHTS**

PATIENT RESPONSIBILITIES

1. Provide complete and accurate information to the best of his/her ability about his/her health (i.e., complaints, past illnesses, hospitalizations, any other health related issues), any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. Make it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. Follow the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
4. Provide a responsible adult to transport him/her from the procedure center and remain with him/her twenty-four (24) hours, if required by his/her provider.
5. Communicate refusal of treatment with provider.
6. Assure that the financial obligations of his/her care are fulfilled as promptly as possible.
7. Be respectful of all the health care providers and staff, as well as other patients.
8. Follow facility policies and procedures.
9. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Compliance Officer of Heart and Vascular Care. Please submit complaint(s) to the following: Compliance Officer, 3970 Deputy Bill Cantrell Memorial Road, Ste. 100, Cumming, GA 30040 Phone: 678-513-2273 / Fax: 678-513-8869

If the complaint is not resolved to the patient's satisfaction, he/she has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should either call any of the complaint units or send a written complaint. The patient should provide the physician of surgery center name, address, and specific nature of the complaint.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the Compliance Officer of Heart and Vascular Care. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within ten (10) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights.

_____ _____

Patient Signature **Date**

_____ _____

Printed Name (if not the patient) **Relationship to Patient**