Peter C. Maki, MD, FACC
Timothy J. Byrne, DO, FACC
Neal A. Klein, MD, FACC
Gopi Cherukuri, MD, FACC
J. Michael Morgan, MD, FACC
William M Jaffe, DO
Akil Loli, MD, FACC
Jason Cool, MD
Marwan M Bahu, MD
Michelle Mix, MD, FACC
Basil Alkhatib, MD, FACC
Nicholas X. Jebaily, MD

Dear Valued Patient,

Enclosed you will find the paperwork necessary for your appointment with Biltmore Cardiology. Please fill it out completely in ink and bring it with you on the day of your appointment.

We would like to take this time to thank you for choosing Biltmore Cardiology for your cardiac care. If you have any questions, please do not hesitate to call. Phone service directly to the office is 8:00 am to 5:00 pm Monday through Thursday. Friday hours are 8:00 am to 3:00 pm, with the answering service providing coverage during off hours.

Please remember to bring the following: Your completed forms, along with your insurance card, medication list and a photo ID. Copayments are due at the time of your appointment.

If you are having testing performed at our facility, please remember that **we do not allow children in the testing area and person(s) accompanying you must remain in the main lobby.**

Again, thank you for choosing Biltmore Cardiology. We look forward to seeing you on your scheduled appointment date.

BILTMORE CARDIOLOGY LOCATIONS

BC MAIN
4444 N. 32nd Street, Suite 175
Phoenix, AZ 85018
602-952-0002 Phone
602-224-9119 Fax

BC CASA GRANDE
1890 East Florence Blvd., Suite 1
Casa Grande, AZ 85122
520-381-8850 Phone
520-381-8851 Fax

BC Payson
708 Coeur D' Alene Lane, Suite 1
Payson, AZ 85541
928-472-7440 Phone
928-472-7536 Fax

BC WICKENBURG
519 W. Rose Lane
Wickenburg, AZ 85390
602-952-0002 Phone
602-224-9119 Fax

Biltmore Cardiology

PATIENT DEMOGRAPHICS

Last Name________________________________ First Name ___________________________ Middle Initial___________

SSN______________________ DOB__________________ Sex: M ☐ F ☐

Address:_______________________________________ City_______________ State ________ Zip Code: ________

Race (i.e. Caucasian/Hispanic/Asian)________________________________ Primary Language:_____________________

Ethnicity (i.e. American/Mexican/German)___________________________

How may we contact you? Home Phone ☐ Cell Phone ☐ May we leave a detailed message? Y ☐ N ☐
Marital Status: S ☐ M ☐ W ☐ D ☐ Do You Smoke: Y ☐ N ☐

Home Phone___________________________ Cell Phone ________________________ Work Phone ___________________

E-mail Address

Primary Care Provider ____ Phone________________________________

Referring Provider ____ Phone________________________________

Preferred Appointment Reminder Method: Phone ☐ Mail ☐ E-mail ☐ Text ☐

Retired: Y ☐ N ☐ Occupation or Former Occupation ____

Primary Insurance Name: ____

Primary Insurance **Holder Name**: _______________________________ DOB: _______________ Relationship: ________________

Secondary Insurance Name: ____

Secondary Insurance **Holder Name**: _____________________________ DOB: _______________ Relationship ________________

ASSIGNMENT OF BENEFITS

I hereby authorize my benefits to be paid directly to Biltmore Cardiology, PLLC and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

____ ____________________________________

Signature of Patient or Legal Representative Date

____ ____________________________________

Legal Representative Name Relationship to Patient

MEDICAL HISTORY

Name: ______________________________________ DOB: ______________________________ Age: ___________________

Occupation: __________________________ Retired: Y or N If retired, previous occupation: ______________________

Marital Status: Single Married Separated Divorced Widowed Name of Spouse: _________________________

Primary Care Doctor: ____ Primary Care Phone#: ____________________

Referring Doctor: ____

Reason for Visit: ____

Medications

Local Pharmacy Name: ____ Phone: ______________________

Major Cross Streets: _____________________________________ and ____

Mail Order Pharmacy Name: ____

Please list the medications you are <u>currently</u> taking:

Drug	Dosage	How often per day?

Please list any Drug/Medication Allergies:

Drug	Reaction

ADDITIONAL ALLERGIES (foods, adhesive tape, X-Ray dye, latex, etc.) Yes ☐ No ☐

Allergy	**Reaction**
________________________	________________________
________________________	________________________
________________________	________________________

Surgeries and Procedures

Heart Surgery Yes ☐ No ☐
(i.e. Coronary Bypass, Valve Replacement, Transplant, etc)

Surgery: ______________________
Facility: ______________________
Date: ______________________

Vascular Surgery Yes ☐ No ☐
(i.e. Bypass Graft, Angioplasty, Stents, etc)

Surgery: ______________________
Facility: ______________________
Date: ______________________

Cardiovascular Procedures/Intervention Yes ☐ No ☐
(i.e. Cath/Angiograms, Stents ,PTCA, etc)

Surgery: ______________________
Facility: ______________________
Date: ______________________

Do you have difficulty with anesthesia? Yes ☐ No ☐

Other Surgeries:

Type:________________________ Facility: ______________________
Date: ______________________

Type:________________________ Facility: ______________________
Date: ______________________

Personal History and Risk Factors

Have you been diagnosed with any of the following?

Diabetes	Yes	No	When: ____________________
Hypertension (High Blood Pressure)	Yes	No	When: ____________________
Dyslipidemia (increased lipids in blood)	Yes	No	When: ____________________
Peripheral Vascular Disease (PVD)	Yes	No	When: ____________________
Heart Valve Disease	Yes	No	When: ____________________
Thyroid Disorder	Yes	No	When: ____________________
Bleeding Tendencies	Yes	No	When: ____________________
Kidney Problems	Yes	No	When: ____________________
Lung Disease	Yes	No	When: ____________________
Stroke	Yes	No	When: ____________________
Heart Attack (Myocardial Infarction)	Yes	No	When: ____________________

Have you ever experienced or have been diagnosed with:

Palpitations (racing heart or skipped beats)	Yes	No	When:____________________
Fainting	Yes	No	When:____________________
Near-Fainting	Yes	No	When:____________________
Cardiac Arrest	Yes	No	When: ____________________
Shortness of Breath	Yes	No	When: ____________________
Chest Discomfort	Yes	No	When: ____________________
Leg Swelling	Yes	No	When: ____________________
Congestive Heart Failure	Yes	No	When:____________________

Family History

Family History Of Coronary Artery Disease (CAD)? **Yes** ▢ **No** ▢ **Unsure** ▢ **Adopted? Yes** ▢ **No** ▢

Mother *Alive(*age)__________ Deceased __________ Cause____

Health Problems:____

Father *Alive(*age)__________ Deceased__________ Cause____

Health Problems:____

Brother *Alive(*age)__________ Deceased_________ Cause____

Health Problems:____

Sister *Alive(*age)__________ Deceased ________ Cause____

Health Problems:____

Child(ren) *Alive(*ages) ________Deceased________ Cause____

Health Problems:____

Child(ren) *Alive(*ages)________Deceased________ Cause____

Health Problems:____

Social History

Do you have an Advanced Directive, Living Will or Healthcare Power of Attorney? Yes ▭ No ▭

Are you following a special diet? Yes ▭ No ▭ If yes, what? ______________________________

Do you exercise? Yes ▭ No ▭ If yes, what and how often?________________________

Do you smoke? Yes ▭ No ▭ If yes, what____________ how much _____________how often ______________

Have you EVER smoked: Yes ▭ No ▭ If yes, what _________ how much____________ Year Quit__________

Alcohol Use: Current ▭ How much and how often? ______________
Never ▭
Former ▭ Year Quit __________

Drug Use: Current ☐ What and how often? ____________________
Never ☐
Former ☐ Year Quit ____________

Caffeine Use: Current ☐ What and how often? ____________________
Never ☐
Former ☐

Review of Systems

Are you currently experiencing any of the following symptoms? (Please check all that apply.)

Cardiac/Vascular	Chest Pains or angina	☐	Swelling of feet, ankles or hands	☐
	Palpitations	☐	Leg pain when walking	☐
	Syncope (fainting)	☐	Varicose Veins	☐
Constitutional	Recent weight change	☐	Fatigue	☐
Respiratory	Chronic or Frequent Cough	☐	Spitting up Blood	☐
	Shortness of Breath on Exertion	☐	Shortness of Breath at rest	☐
	Asthma or Wheezing	☐	Snoring	☐
Gastrointestinal	Loss of Appetite	☐	Nausea or Vomiting	☐
	Blood in Stool	☐	Abdominal Pain	☐
Musculoskeletal	Joint pain	☐	Muscle weakness or pain	☐
Skin/Derm	Rash	☐	Skin sores	☐
Neurological	Frequent Headaches	☐	Lightheaded or dizzy	☐
	Seizures	☐	Stroke or TIA	☐
	Tremors	☐	Memory Loss	☐
Psychiatric	Nervousness or Anxiety	☐	Depression	☐
	Difficulty Sleeping	☐	Hallucinations	☐
Genitourinary	Blood in Urine	☐	Frequent Urination	☐
	Painful or Burning Urination	☐		
Hematology	Anemia	☐	Bleeding or Bruising tendency	☐
HEENT	Hearing Loss	☐	Vision Changes	☐

____________________________________ ____________________
Patient Signature Date

Biltmore Cardiology

Consent Form

Name: ____ Date of Birth: ______________________

Subscriber Name: ____________________________________ Date of Birth: _____________________

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Do you have an Advance Directive? (Legal document expressing your critical care wishes when you are unable to decide for yourself)
Yes ☐ No ☐

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Biltmore Cardiology, PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Biltmore Cardiology, PLLC at any time to obtain a current copy.

**Signature:___________________________________ Date: _____________________________

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name: ________________________________ Relationship:__________________ Phone:________________

Name:_________________________________ Relationship:________________ Phone:________________

Name: ________________________________ Relationship:__________________ Phone: ________________

**Signature_______________________________________ Date:_________________________________

Notice of Electronic Access to Prescription History:

By signing below, I authorize Biltmore Cardiology, PLLC to obtain my medication history from my pharmacy electronically.

**Signature:___________________________________ Date: _____________________________

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

**Signature:___________________________________ Date: _____________________________

Acceptance of Patient Portal Authorization:

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Agreement.

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | |

**Signature:____________________________________ Date:______________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH AND FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Biltmore Cardiology, PLLC is required by law to maintain the privacy of your health and financial information. We realize that these laws are complicated, but we must provide you with the following important information. Biltmore Cardiology, PLLC will not use or disclose your protected health and financial information except as described in this notice.

TREATMENT: Biltmore Cardiology, PLLC will use your protected health and financial information in the provision and coordination of your healthcare. Biltmore Cardiology, PLLC may disclose all or any portion of your protected health and financial information to your attending physician, consulting physician(s), nurses, technicians, medical students, and other health care providers who have a legitimate need for such information in your care and continued treatment. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you or to other physicians who may be treating you.

TREATMENT ALTERNATIVES: Biltmore Cardiology, PLLC may use and disclose your protected health and financial information to tell you about or recommend a possible treatment option or alternative that may be of interest to you.

FAMILY / FRIENOS: Biltmore Cardiology, PLLC may NOT release protected health and financial information about you to a friend or family member without your expressed written consent.

PAYMENT: Biltmore Cardiology, PLLC may release protected health and financial information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company for the coordination of benefits and to obtain payment. Biltmore Cardiology, PLLC may provide information to them about you and the care given, which may include copies or excerpts of your medical records, which are necessary for payment of your account. For example, a bill sent to an insurance company might include information that identifies you, your diagnosis, and the procedures and supplies used.

ROUTINE HEALTHCARE OPERATIONS: Biltmore Cardiology, PLLC may use and disclose your protected health and financial information during routine health operations; which include, but are not limited to, the possible use of a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the reception area when your physician is ready to see you.

PHONE CONTACTS: Biltmore Cardiology, PLLC may use and disclose protected health information as necessary to remind you of your appointment.

HEALTH RELATEO BUSINESS & SERVICES: Biltmore Cardiology, PLLC may use and disclose protected health and financial information to tell you of health related benefits or services that may be of interest to you.

BUSINESS ASSOCIATES: Biltmore Cardiology, PLLC may use and disclose certain protected health and financial information about you to business associates. A business associate is an individual or entity under contract with Biltmore Cardiology, PLLC which necessitates the use and disclosure of protected health and financial information. For example, may include, but is not limited to, copy services used by Biltmore Cardiology, PLLC to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. These business associates also have the obligation to protect the confidentiality of your protected health information.

REGULATORY AGENCIES: Biltmore Cardiology, PLLC may disclose your protected health and financial information to a government oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections. In addition, Biltmore Cardiology, PLLC may disclose your protected health information to certain private oversight health agencies such as accreditation organizations.

LAW ENFORCEMENT / LIGITATION: Biltmore Cardiology, PLLC may disclose your protected health and financial information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

PUBLIC HEALTH: Biltmore Cardiology, PLLC as required by law, may disclose your protected health and financial information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, Biltmore Cardiology, PLLC is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome (AIOS), to the Arizona State Department of Health Services to protect the health and well being to the general public.

WORKER'S COMPENSATION: Biltmore Cardiology, PLLC may release protected health and financial information about you to your employer, your worker's compensation carrier and/or the appropriate industrial commission for worker's compensation benefits or similar programs.

MITLITARY / VETERANS: Biltmore Cardiology, PLLC may disclose your protected and financial information as required by military command authorities, if you are a member of the armed forces.

FOA: Biltmore Cardiology, PLLC may disclose your protected health and financial information to a person or company required by the Food and drug Administration to report adverse events, product defects of problems, biologic product

deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

INMATES: Biltmore Cardiology, PLLC may use your protected health and financial information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

REQUIREO BY LAW: Biltmore Cardiology, PLLC may disclose protected health and financial information about you when required to do so by law. For example, Biltmore Cardiology, PLLC may disclose certain protected health and financial information to those persons who have a risk exposure related to a communicable disease, according to Arizona law.

CORONERS, FUNERAL DIRECTORS, ANO ORGAN OONORS: Biltmore Cardiology, PLLC may disclose protected health information to a coroner or medical examiner for identification purposes; determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. Biltmore Cardiology, PLLC may also disclose protected health information to a funeral director to carry out their duties. Biltmore Cardiology, PLLC may disclose such information in reasonable anticipation of death for cadaveric organ, eye, or tissue donation purposes.

OTHER USES: Any other use and disclosures not allowed by law or regulation will be made only with your written authorization. If you would ever like to revoke your permission, please notify the office in writing.

PATIENT HEALTH INFORMATION RIGHTS:
Although all records concerning your medical care and treatment obtained at Biltmore Cardiology, PLLC are the property of Biltmore Cardiology, PLLC you have the following rights concerning your protected health and financial information:

RIGHT TO CONFIOENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your protected health and financial information by alternative means or at alternative locations. For example, you may request that Biltmore Cardiology, PLLC only contact you at home or by mail.

RIGHT TO REQUEST ANO INSPECT A COPY: You have the right to request inspection and request a copy of your protected health and financial information provided your physician does not deem said information to be potentially harmful to you or your recovery. A reasonable fee may be charged for these services.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures of your protected health and financial information that occurred after April 14th, 2003, as provided by the HIPAA Federal Privacy Law and Regulations. You have the right to one free accounting in a 12 month period.

RIGHT TO AMEND: You have the right to request an amendment to your protected health and financial information according to Biltmore Cardiology, PLLC privacy policy.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your medical records, protected health information as provided by the Federal Privacy Law. Biltmore Cardiology, PLLC may decide not to honor your request.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this notice upon request.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke your authorization to use or disclose your protected and financial information except to the extent that action has already been taken based on original authorization. You may do so by delivering a written request to the Biltmore Cardiology, PLLC office.

FOR MORE INFORMATION OR TO REPORT
A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Biltmore Cardiology, PLLC or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, O.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Biltmore Cardiology, PLLC
Angel Rodgers
Privacy Officer
4444 N. 32nd St.
Suite 175
Phoenix, AZ 85018
Phone:(602) 952-0002
Fax: (602) 224-9119

NOTICE OF PRIVACY PRACTICES AVAILABILITY: This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on our Web site for downloading.

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARO(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may then be added to your account.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release*: I, the undersigned, authorize payment of medical benefits to* ***Biltmore Cardiology, PLLC*** *for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.*

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please note: If you have applied for AHCCCS and are in the "Pending" status and your AHCCCS request is declined, you will revert to self-pay status with this office and payment in full will be required by you.

- **MEOICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File*: I request that payment of authorized Medicare benefits be made on my behalf to* ***Biltmore Cardiology, PLLC*** *for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.*

- **OIVORCEO/SEPARATEO PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Biltmore Cardiology, PLLC will not be involved with separation or divorce disputes.

  You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment, you will be additionally held responsible for any/all charges Biltmore Cardiology, PLLC incurs as a result of this.