1978-2018

HEART CENTER OF NEVADA

1978-2018

NEW PATIENT INFORMATION AND UPDATE

Referred by: _____

Primary care Doctor: _____

Name_____

Employer _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____

Home Phone _____

Position _____

Cell Phone _____

E-mail _____

Date of Birth _____

Emergency Contact:
Name _____
Relation _____
Phone _____

Age _____ Sex _____

Race _____ Ethnicity _____

Social Security# _____ Marital Status _____

PRIMARY INSURACE INFORMATION

Relationship to Insured: Self___ Spouse ___ Dependent

Ins Company Name _____

Insured's Name _____

Policy # _____

Insured's DOB _____ SS# _____

Employer _____

SECONDARY INSURACE INFORMATION

Ins Company Name _____

Insured's Name _____

Policy # _____

Insured's DOB _____ SS # _____

Employer _____

AUTHORITY AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical information necessary to process this claim and request that payment of medical benefits be paid directly to Heart Center of Nevada for services provided.

SIGNED _____ DATE _____

I, _____, authorize Heart Center of Nevada to release information either in writing or verbally relating to my medical condition to the following people:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____
Signature

_____
Date

ATTENTION PATIENT

IT IS THE RESPONIBILITY OF THE PATIENT/ INSURED TO KNOW WHETHERE THE DOCTOR YOU ARE SEEING FOR MEDICAL SERVICES IS A PROVIDER ON YOUR INSURANCE AND TO PROVIDE A REFERRAL, IF NECESSARY, UPON ARRIVAL. IF NOT, **YOUR APPOINTMENT WILL BE RESCHEDULED.**

YOU AS THE INSURED ARE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE OR DEDUCTIBLE AT THE TIME OF SERVICE.

IF OUR OFFICE IS NOTIFIED BY YOUR INSURANCE COMPANY FOR INELIGIBILILY OF BENEFITS, OR THAT YOU ARE NO LONGER INSURED,
YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL. YOU AS THE PATIENT ARE ALSO RESPONSIBLE TO PAY YOUR DEDUCTIBLE IN FULL.

IF THERE ARE ANY PROBLEMS, YOU WILL BE SUBJECT TO COLLECTIONS.

SIGNED: _____ DATE: _____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control our protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclosed your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed to obtain payment for your health care services.For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addiction, we may use 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 waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law: Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, funeral Directors, and Organ Donations; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Users and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosed of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive and accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints:
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before **April 14, 2003.**
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 702-384-0022.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature:_____ Date: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____Date:_____

Address: _____

City: State: Zip: _____

I hereby request that my medical records be released to:

Physician's Name (Print) _____

Location

_700 Shadow Lane, Ste. 240
Las Vegas, Nv 89106
702-384-0022
Fax: 702-384-0529

_1815 E. Lake Mead Blvd., Suite 110
N. Las Vegas, Nv 89030
702-642-9010
Fax: 702-642-0717

_ 5380 S. Rainbow Blvd, Ste 226
Las Vegas, Nv 89118
702-260-0022
Fax: 702-260-0200

_4275 S. Burnham Ave, Ste 370
Las Vegas, Nv 89119
702-732-0022
Fax: 702732-4532

_ 6850 N Durango Dr. Ste 205
Las Vegas, Nv 89149
702-433-0022
Fax: 702-433-0322

Patient to complete below:

Patient's Name **(PRINT)** _____

Patient's Signature _____

Patient's Address _____

City: State: Zip: _____

Date of Birth: Social Security Number:_____

MEDICATION LIST

Patient Name: _____ Doctor: _____

Date of Birth: _____ Age: _____

Med Allergies: 1._____ 2._____ 3._____

Diagnosis: 1._____ 2. _____ 3. _____

Current Medications:

Drug	Strength	Frequency

PERIPHERAL ARTERIAL DISEASE (PAD) SCREENING AND ASSESSMENT

Name _____ Age_____ Date_____

PAD/ Claudication Symptom Review

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk? **Yes** **No**

   a. If yes, does the pain go away within 10-minutes after stopping? **Yes** **No**

   b. Does anything limit your walking ability? **Yes** **No**

   c. Do you ever need to stop and rest when you are walking? **Yes** **No**

   d. Do you ever use assistance to walk (i.e., walker, cane, motorized cart, someone's harm)? **Yes** **No**

   How far can you walk? Blocks _____? Miles _____? Unable to walk **Yes** **No**

2. Do you have discomfort or difficulty if you walk up an incline, go up stairs, or walk at an increase speed? **Yes** **No**

3. Do you experience any pain at rest in your lower leg(s) or feet? **Yes** **No**

4. Do you wake up in your sleep because you have tingling or numbness in your leg muscles? **Yes** **No**

   a. Does this happen more than once a week? **Yes** **No**

CLI Symptom Review

5. Do you have an infection, skin wound or ulcer on your calf, feet or toes that are slow to heal (6 week+) **Yes** **No**
6. Are your toes or feet pale, discolored, or bluish? **Yes** **No**

Risk Factor Assessment

7. Do you have Diabetes? **Yes** **No**
8. Do you have coronary artery disease? **Yes** **No**
9 Do you have a history of chronic kidney disease? **Yes** **No**
10 Have you been diagnosed with abdominal aortic aneurysm? **Yes** **No**

Please check any that apply: **___ Stroke, mini-stroke and (TIA)** **___ History of Smoking**

___ Prev- Vascular Surgery **___ High Cholesterol** **___ High blood pressure** **___ Age >50**