

JACKSON  CARDIOLOGY
CONSULTANTS

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205 Page Ave
Jackson, MI
49201

214 N. West Ave
Jackson, MI
49201

Patient Payment Agreement

Patient Account (MRN): _____

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

City/State/Zip: _____

Email: _____

Credit Card Information:

- Card Number: _____
- Expiration Date: _____
- CVV/Zip Code: _____ / _____

Agreement Terms:

1. **Responsibility for Charges:** The undersigned patient agrees to be responsible for all charges incurred during their treatment at Jackson Cardiology Consultants. This includes, but is not limited to, consultation fees, treatment costs, and any other related expenses.
2. **Payment Plan Agreement:** The patient agrees to the payment plan outlined by Jackson Cardiology Consultants. The details of the payment plan are as follows:
 - Total Amount Due: \$ _____
 - Monthly Payment Amount: \$ _____
 - Monthly Payment Due Date: _____
3. **Authorization:** By signing below, the patient authorizes Jackson Cardiology Consultants to charge the above credit card for the agreed-upon payment plan amounts. The patient also agrees to notify Jackson Cardiology Consultants of any changes to their credit card information.

Signature: _____

Date: _____



MEDICAL RECORDS RELEASE FORM

To: _____

I _____ (patient's name), hereby authorize you to release my medical records as they apply to me during the period from to or the specific information related to: _____

These records are to be released to:

Jackson Cardiology Consultants
205 Page Ave.
Jackson, Mi 49201
Phone (517) 787-3577 Fax: (517) 787-4280

Patient's Name (Please Print)

Date of Birth

Patient's Address

Patient's Phone Number

Patient's Address Continued

Signature

Date

Witness



Social Determinants of Health Screen

We know that social factors may impact your overall health. Because of that, we now have a unique opportunity to help you beyond your medical needs! Please take a moment to answer the questions below, putting a check mark in the "yes" or "no" columns. If you answer "yes" to any of the questions below, we will be able to connect you to a member of our Care Coordination team for assistance, with your consent.

Domain	Question	Yes	No
Healthcare	Does your physical or mental health keep you from doing things you need or want to? (work, school, take care of yourself)		
	Have you needed to see a provider but could not because of cost?		
Food Insecurity	Have you or a family member you live with been unable to get food when it was needed in the last year?		
Housing & Shelter	Do you need help with housing?		
	Are you homeless or worried that you might be in the future?		
Financial Resource and Strain	Do you have a hard time paying your utility bills?		
Family Care	Do you need help finding or paying for care for loved ones? For example, child care or day care for an older adult.		
Transportation	Do you have trouble finding or paying for transportation?		
Literacy	Do you ever need help reading important papers?		
	Do you have any legal concerns at this time?		
Employment & Income	Do you need help finding a job, better job, or steady source of income?		
Education	Do you think more education could be helpful for you?		
Social Connections	Do you struggle to get together with friends or family on a regular basis?		
Safety	Are you afraid you might be hurt in your living environment?		
General	Would you like assistance with any of these needs? (by checking 'Yes', you agree to allow us to share your information with our Care Coordination team who will link you to applicable resources in the community)		
	Are any of your needs urgent?		

Internal Use Only:

- HFCC JHN SDOH flowsheet completed in Epic
- If applicable, notified Care Manager of referral

**JACKSON CARDIOLOGY
CONSULTANTS**

Name _____

Goal

JACKSON  CARDIOLOGY
CONSULTANTS

Name: _____

Date: _____

Birthdate: _____

Age: _____

Do you have:

- High Blood Pressure: _____
- High Cholesterol: _____
- Insulin Resistance/Diabetes: _____
- Varicose Vein: _____
- Blood Clots: _____
- Raynaud's Syndrome: _____
- Cold Feet/Legs: _____
- Family History of Stroke or Vascular Disease: _____
- Hair loss or slower hair growth on feet & legs: _____
- Change in color on the legs or feet: _____
- Slower growth of the toenails: _____
- Numb or heavy sensation in the muscles: _____
- Thin or shiny skin on the feet & legs: _____
- Swelling: _____

Yes No

Have you RECENTLY experienced any of the following

- Chest pain, Pressure or discomfort with or without activity _____
- Excessive sweating with chest pain or palpitations _____
- Skipping, racing or pounding heartbeat _____
- Near fainting, passing out or lightheadedness _____
- Shortness of breath at rest or with activity _____
- Shortness of breath while lying flat _____
- Pain, or cramping in legs with or without activity _____
- Excessive urination during the night _____

Yes No

Please circle any of the following that you have:

Depression	Ulcers on the legs	Skin rash or sores
Memory loss	Pain in the muscles	Snoring
Weakness	Joint pain	Visual changes
Easy bruising	Dizziness	Abnormal pain
Heat intolerance	Blood in the urine	
Cold intolerance	Indigestion or heart burn	



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

(HIPAA)

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

Signature

Date

Please indicate below if you would like us to release any information to a member, caretaker, or durable power of attorney.

Name

Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement.
- An emergency prevented us from obtaining acknowledgement.
- Other (please specify): _____

CO-PAY, BALANCE, NO SHOW AND RECORD CONSENT

As a courtesy, and to help patients remember their scheduled appointments, Jackson Cardiology Consultants, PLLC sends reminders 3-5 days in advance of the appointment via My Chart and 2-3 days in advance of any testing via phone.

All co-pay and balances are due at the time of the visit. If you are unable to pay co-pay and/or balance at visit you can make a payment arrangement. Appointment will be cancelled or rescheduled if payment or arrangement is not made at the time of visit.

If you do not cancel or reschedule your appointment with the physician with at least 24-hour notice, we will assess a \$50.00 "no show" service charge to your account. If you do not cancel or reschedule your appointment for testing, you will be charged \$100.00 "no show" service charge for each testing to your account. If you do not cancel or reschedule your appointment for Stress Testing with at least 24-hour notice, we will assess a \$175.00 "no show" to your account. If you do not cancel or reschedule your testing for Venous Ablation Procedure with at least a 24-hour notice, we will assess a \$750.00 "no show" fee to your account. This "no-show" charge is not reimbursed by your insurance company. You will be billed directly for it. After three consecutive "no shows" for an appointment Jackson Cardiology Consultants, PLLC may decide to terminate its relationship with you.

CONSENT TO ACCESS, USE OR DISCLOSE OF PROTECTION HEALTH INFORMATION

I understand that it's the intent of the provider to hold all my identifiable health information (medical information or "PHI") with the utmost level of confidentiality. I authorize and give consent to my provider, His/Her/Its permitted users to create and use EHR which includes disclosing my PHI to JCMR and other healthcare Providers who provide me with healthcare services, for my continuing care and treatment, payment, health care operations, and as described in each providers privacy notice. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to provider and his/her/its designees for services rendered.

AUTHORIZATION FOR ACCESS TO JDMR MEDICAL RECORD AND RELEASE OF INFORMATION

If a JCMR EHR has already been created for me, I consent and authorize the provider and permitted users to access my JCMR EHR for my continuing care and treatment, payment or healthcare operations. This includes my consent to release and disclosure of any medical information necessary. I also authorize payment of medical health insurance benefits to be made directly to the provider and designees for service rendered.

I have read this form, and I understand that I must cancel or reschedule any appointment within 24 hours.

Patient Name: _____ **Date:** _____

Patient Signature: _____