Patient Information Form

DESERT CARDIOVASCULAR CONSULTANTS
Zia U. Khan, MD, FACC, FSCAI
Cardiac and Peripheral Interventions
Chief, Division of Cardiology & Director Cardiac Cath Lab
Summerlin Hospital Medical Center

Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Home Address: _____ City: _____ Zip: _____

Social Security #: _____ Date of Birth: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest Friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Doctor: _____ Phone: _____

Whom may we contact in the case of an emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Did you sustain an injury at work?
Y N

Are you covered under an employer or union policy?
Y N

Are your injuries accident related?
Y N

Is your spouse or other family member employed?
Y N

Are you currently employed?
Y N

Do you have a secondary insurance policy?
Y N If, yes who is your secondary: _____

Have you ever served in the military?
Y N

Are you covered under any other health care plan?
Y N

Have you made any changes to your choice of Medicare options in the last open enrollment period?
Y N

Are you enrolled in a Medicare Advantage Plan?
Y N If, yes what Medicare Advantage Plan: _____

I am a new patient to this practice and I am in a pre-existing provision with my insurance carrier.
Y N

Who is responsible for this bill? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

DESERT CARDIOVASCULAR CONSULTANTS
Zia U. Khan, MD, FACC, FSCAI

Primary Insurance Information:

Insurance Company Name: _____

Address: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Social Security #: _____

Relationship of Patient to Policy Holder: _____

Insurance Phone #: _____

Secondary Insurance Information:

Insurance Company Name: _____

Address: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Social Security #: _____

Relationship of Patient to Policy Holder: _____

Insurance Phone #: _____

Tertiary Insurance Information:

Insurance Company Name: _____

Address: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Social Security #: _____

Relationship of Patient to Policy Holder: _____

Insurance Phone #: _____

Assignment of Benefits Form

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Practice Name: **DESERT CARDIOVASCULAR CONSULTANTS** Date: _____

Address: **5785 S FORT APACHE RD STE A 100** Patient: _____

City, State, Zip: **LAS VEGAS NV 89148** ID#: _____

Phone: (702)822-2273 Group#: _____

I, understand that services rendered to me by **DESERT CARDIOVASCULAR CONSULTANTS**

Are my financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to **DESERT CARDIOVASCULAR CONSULTANTS.**

I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment on the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **DESERT CARDIOVASCULAR CONSULTANTS** within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed to **(provider)** immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **DESERT CARDIOVASCULAR CONSULTANTS** to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated _____ Witness _____

_____ _____

Signature of policyholder Patient or Guardian

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5785 South Fort Apache, Ste. A-100, Las Vegas, NV 89148
Phone: (702) 822-2273 Fax: (702) 734-3278

Personal/Confidential Information

"Confidential Information" means any and all non-public, medical, financial and personal information in whatever form (written, oral, visual or electronic) possessed or obtained by either party. Confidential Information shall include all information which (i) either party has labeled in writing as confidential, (ii) is identified at the time of disclosure as confidential, (iii) is commonly regarded as confidential in the health care industry, or (iv) is Protected Health Information as defined by HIPAA.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Neurosurgery, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Request Restrictions

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

You have the right to view and obtain a copy of much of your health information and to have corrections made to such information.

The Privacy rule gives you the right of access to inspect and obtain a copy of your designated record set. A designated record set is the medical records, billing records, enrollment claims, claim records, and other information used to make decisions about the individual. A PHR offered by a HIPAA covered entity may allow individuals to view all or part of their PHI held by a covered entity and to download and print this information. Thus, depending on the breadth and usefulness of the information to which the individual has access, a PHR could eliminate or reduce the need for individuals to otherwise request access to their complete designated record set held by the HIPAA covered entity. However, access to health information through a PHR would not replace an individual's right to obtain access to health information in his or her designated record set that is not available through the PHR and to which he or she is entitled under the Privacy Rule. Thus, covered entities providing the individual with access to only a portion of the individual's health information in a designated record set through a PHR should make clear the individual's right to obtain access to the information in the designated record set that is not available through PHR. Also, individuals always retain the right to a paper copy of the individual's health information in the designated record set held by the covered entity. In addition, the Privacy Rule requires a covered entity to have a mechanism to provide an individual's personal representatives with access to the individual's PHI and, as with access provided to the individual, a PHR may be a way to eliminate or reduce the need for personal representatives otherwise request access to the complete designated record set about the individual. Additionally, covered entities are not precluded from setting up a PHR system that allows individuals to designate family members or other persons to have access to the information in their PHRs.

Right to Amend

The Privacy Rule gives individuals the right to have amendments or corrections made to the PHI in their heal records or other designated record set held by a covered entity. PHRs that replicate some or all of the information in the health record may be helpful mechanisms for individuals to identify potential errors in their health information and to request that the covered entity correct the information. If there is a mistake, the covered entity can correct or append additional information to the individual's health information held in the covered entity's health records system and can update the PHR with the corrected information. The individual control inherent in PHRs also may allow individuals to revise and update some information, such as that information they themselves have entered in their PHRs

Right to Receive an Accounting

The Privacy Rule gives individuals the right to receive an accounting of certain disclosures of their PHI made by a covered entity for the six years prior to the request for the accounting, so that individuals are aware of how their information has been shared. However, because disclosures from the PHR will generally be to the individual or for limited other purposes, such as for administering the PHR, disclosures of information from a PHR generally would not be subject to the HIPAA accounting requirement. However, consistent with the intent of the accounting for disclosures, covered entities may want to consider setting up a functionality within a PHR that provides individuals with the ability to view a log of who accessed their PHR.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to prove those services or complete those activities.

Right to Complaint

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy office, DESERT CARDIOVASCULAR CONSULTANTS. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to DESERT CARDIOVASCULAR CONSULTANTS.

Print Name:_____ Date:_____

Signature:_____

DESERT CARDIOVASCULAR CONSULTANTS

Zia U. Khan, MD, FACC, FSCAI

5785 South Fort Apache, Ste. A-100, Las Vegas, NV 89148
Phone: (702) 822-2273 Fax: (702) 734-3278

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby request that my medical records be released to:

Dr. Zia U. Khan, MD, FACC, FSCAI

DESERT CARDIOVASCULAR CONSULTANTS

5785 South Fort Apache, Ste. A-100, Las Vegas NV 89148

Phone: (702) 822-2273 Fax: (702) 734-3276

Patient's Name: _____

Patient's Signature: _____

Patient's Address: _____

City: _____ State: _____ Zip:

Date of Birth: _____ SSN: _____

Patient's Phone Number: _____

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Assessment of Venous Insufficiency

Name_____DOB_____Date_____

Assessment: Varicose Veins Spider Veins

Level of Severity: 1 2 3 4 5 6

Does the patient have any symptoms due to venous insufficiency? Yes No

If yes, what symptoms does the patient have.

Pain Swelling Cramping Aching Heaviness Burning Itching Color Change

Do symptoms interfere with activities of daily living? Yes No
If yes, what activities?_____

_____

Does the patient take over the counter or prescription medication to relieve symptoms? Yes No
If yes, what medication and dosage_____
How many days did the patient have to use medication within 2 weeks?_____

Does the patient's activities require prolonged periods of standing? Yes No
If yes, how many times the patient take a break or sit due to the symptoms?_____

Has the patient experienced intractable ulceration due to venous stasis? Yes No

Has the patient had more than 1 episode of minor hemorrhage from a ruptured superficial varicosity? Yes No

Has the patient had a hemorrhage that required a blood transfusion? Yes No

Has the patient had surgical, laser, or radiofrequency treatment for CVI before? Yes No
If yes, please describe_____

Has the patient tried to wear compression stockings? Yes No
If yes, how long?_____
If no, was 20-30mmHg thigh high stockings given today? Yes No

Signature:_____Date:_____

Desert Cardiology Consultants

Cardiovascular Risk Assessment and Patient history Form

Thank you for taking the time to fill out our health questionnaire. This will allow us to better serve your health needs. This is confidential record of your medical history and will be kept confidential.

Today's date: Name: DOB:

Primary Care Provider:

Problem today:

Past Medical History: (please indicate "Y" for yes or "N" for no. If uncertain write "?")

High blood pressure_____ Diabetes_____ high cholesterol_____ Heart attack_____

Heart Catheterization_____ Angioplasty_____ Congestive heart failure_____ Stroke_____

Valve problem/murmur_____ Rheumatic Fever_____ Loss of consciousness_____

Arrhythmia (irregular heart beat)_____ Emphysema_____ Pneumonia _____ Anemia_____

Liver disease_____ Bleeding tendency_____ Ulcers _____ Cancer_____

Autoimmune disease_____ kidney disease _____ Arthritis _____ Glaucoma _____

Headaches/migraines_____ Thyroid disease_____ HIV_____ Asthma_____

Vascular (blood vessel disease)_____ Other _____

Past Surgical History and Hospitalizations: (Please list and give approximate dates) If No check here_____

1._____ 2._____

3._____ 4._____

Family Medical History: If No positive family history please check here_____

Has any blood relative had any of the following (Please indicate "Y" for yes or "N" for no)

High blood pressure_____ Sudden death_____

Diabetes_____ Congestive heart failure_____

High cholesterol_____ Arrhythmia (irregular heart beat)_____

Heart attack_____ Vascular (blood vessel disease)_____

Angioplasty _____ Cancer_____

Coronary bypass surgery _____ Stroke _____

Current medication List

Name: _____

Prescription Medication:

Name of Medication	Strength and frequency	Physician who prescribed Med

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NO SHOW POLICY FOR OFFICE TESTS

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at **least 48 hours (2 days)** advance you will be charged a fee. **This will not be covered by your insurance company.**

LOSS RECUPMENT

PLAIN TREADMILL STRESS TEST $25.00

SLEEP STUDIES $100.00

ENDOVENOUS LASER ABLATE (EVLT) $100.00

CARDIOLITE TREADMILL STRESS TEST $100.00

LEXI SCAN STRESS TEST $100.00

MUGA SCAN $100.00

ALL ULTRASOUNDS $25.00

Print Name _____ Patient Signature/ Guardian _____ Date:

5785 South East A

WATERMARK MEDICAL ARES QUESTIONNAIRE

PATIENT DEMOGRAPHICS			SCORING
Last	First	Middle Initial	Neck Size +2 ≥16.5 (Male) +2 ≥15.0 (Female)
Date of Birth	○ Male ○ Female	ID# Optional	
Height _____feet _____inches	Weight _____pounds	Neck Size _____inches	

MEDICAL CONDITIONS: Have you been diagnosed or treated for any of the following conditions?				+1 for each Yes response
High Blood Pressure	○ Yes ○ No	Stroke	○ Yes ○ No	
Heart Disease	○ Yes ○ No	Depression	○ Yes ○ No	
Diabetes	○ Yes ○ No	Sleep Apnea	○ Yes ○ No	
Lung Disease	○ Yes ○ No	Nasal oxygen use	○ Yes ○ No	Do not assign any points for these eight responses
Insomnia	○ Yes ○ No	Restless legs syndrome	○ Yes ○ No	
Narcolepsy	○ Yes ○ No	Morning headaches	○ Yes ○ No	
Sleep Medication	○ Yes ○ No	Pain Medication	○ Yes ○ No	

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze | 1 = slight chance of dozing | 2 = moderate chance of dozing | 3 = high chance of dozing

Epworth Score **TOTAL** the values from all 8 questions. If 11 or less **Score = 0** If 12 or more **Score = 2**

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk
On average in the past month, how often have you snored or been told that you snore?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	○ +0	○ +0	○ +0	○ +0	○ +0

Habits Score **TOTAL** the values for all answers from first 3 habits questions

I have personally completed this questionnaire. **By signing this agreement,** you acknowledge that you have read, understand, and agree to the terms and conditions of the Patient Authorization form on the reverse side of this form.

Patient Signature_____ Date_____

Patient Phone Number_____

Total all 4 boxes above.

Scoring Chart

≤3 = No Risk
4 or 5 = Low Risk
6 to 10 = High Risk
≥11 = Very High Risk