Kandarp Patel MD F.A.C.C

Heart & Medical Center

DEMOGRAPHICS INFORMATION

FIRST_____ **LAST**_____ **DOB**_____

Race/Ethnicity (circle): Caucasian, Black/African American, Asian, Native American, Pacific Islander, Native Alaskan, Native Hawaiian, Hispanic,

Other_____ **Primary Language Spoken (circle): English, Spanish, Other** _____

ADDRESS_____ **CITY**_____ **STATE** _____ **ZIP CODE**_____

PHONE_____ **CELL**_____ **S/SEC#**_____

PREFERRED CONTACT BY (CIRCLE ONE): HOME# / CELL # E-MAIL ADDRESS_____

EMPLOYER_____ **CITY**_____ **STATE** _____ **ZIP**_____ **PHONE**_____

SPOUSE NAME_____ **S/SEC#**_____ **DOB**_____

EMPLOYER_____ **CITY**_____ **STATE** __ **ZIP**_____ **PHONE**_____

Person responsible for this bill if different from above:

NAME_____ **ADDRESS**_____

CITY_____ **STATE**_____ **ZIP**_____ **PHONE**_____

IN CASE OF EMERGENCY CONTACT:_____

RELATIONSHIP_____ **PHONE**_____

How did you hear about our practice? :_____

Referring Doctor:_____

INSURANCE INFORMATION (Copies of Cards Required)

PRIMARY INSURANCE _____

POLICY#_____ **GROUP#**_____

NAME OF INSURED_____ **DOB**_____

SECONDARY INSURANCE_____

POLICY#_____ **GROUP#**_____

NAME OF INSURED_____ **DOB**_____

I agree and authorize medical treatment as deemed necessary by Core Heart & Medical Center. I hereby authorize Core Heart & Medical Center to furnish information concerning my treatment to insurance companies as deemed necessary and I hereby irrevocably assign to Core Heart & Medical Center all insurance benefits payment to me by my insurance company, not exceeding the charges shown. I understand that I am financially responsible for collecting insurance claims or for negotiating a settlement on a dispute claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his/her account is turned over to an attorney, the undersigned shall be responsible for all cost of collection, including out of pocket expenses, court cost and attorney fees. I request that payment of authorized Medicare benefits be made on my behalf to Core Heart and Medical Center for any services furnished me by that clinic. I authorize any holder of Medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)_____

DATE SIGNED_____

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

FINANCIAL INFORMATION

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, our billing office would be happy to discuss this with you. YOU CAN FIND OUR FEE SCHEDULE ON OUR WEBSITE: www.coreheart.com

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. **This office's policy is to collect this copayment when you arrive for your appointment.**
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

I understand that Core Heart & Medical Center will file a claim with my insurance company for payment of office visits and testing done in our office.

However, I understand I am responsible for all co-pays (due at time of visit), deductibles, and co-insurance as required by my insurance plan.

_____ _____

Patient or Patient Representative Signature Date

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site: www.coreheart.com

DATE OF THIS NOTICE 6/11/2011

PRIVACY OFFICER CONTACT INFORMATION:

Belinda Campbell, Office Manager
86 Stonebridge Blvd, Jackson TN 38305
Phone: 731-300-0227 Fax: 731-300-2059

Kandarp Patel MD F.A.C.C

Heart & Medical Center

NOTICE AND ACKNOWLEDGEMENT

Acknowledgement:

I acknowledge that I have read the posted Notice of Privacy Practices.

_____ _____

Patient or Patient Representative Signature Date

If Patient Representative's signature appears above, please describe Patient Representative's relationship to the patient:

_____

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

RELEASE OF INFORMATION REQUEST

PATIENT NAME_____
DOB_____S/SEC#_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PATIENT ID_____

I, _____, authorize the release of my **protected health information (PHI**), as described in Sections 1 and 2 below.

1. **PHI** Use and Disclosure:
   a. Describe in detail the **PHI** to be used and disclosed (provide as much information such as dates, type of treatment)_____

      _____

      _____

   b. All of my medical records in the custody or control of the recipient of this form should be disclosed and transferred to Dr. Kandarp Patel at Core Heart & Medical Center, which may include information listed below:

      In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following:

      - Please check here if your authorization includes the disclosure of **PHI** pertaining to:
        - Testing and treatment for AIDS, AIDS-related or HIV
      - Please check here if your authorization includes the disclosure of **PHI** pertaining to:
        - Substance Abuse (including alcohol)
        - Mental Health Services (including psychotherapy)

      The purpose of this disclosure is _____

2. Authorization Use and Disclosure

   Core Heart & Medical Center will not release any information without the patient's written consent and signature.
   I authorize Core Heart & Medical Center to disclose my **PHI** described in Section 1 to the following person(s):

   _____

   _____

   Note: If **PHI** is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be no longer protected.

3. Expiration and Revocation
   This authorization will expire on _____or when the following occurs:_____

   _____

   I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I understand that I can cancel this authorization at any time by sending a written request on a standard cancellation form. I understand that cancellation will not affect actions taken before Core Heart & Medical Center receives my request.

PATIENT SIGNATURE_____**DATE**_____

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

Core Heart & Medical Center

Patient History Form

Referring Physician:_____ Primary Physician:_____

Name:_____ DOB:_____/_____/_____ Age:_____

Height:_____ Usual Weight:_____ Sex: Male Female

Why are you seeing the doctor today?

_____

_____

Medical History:

___High/Low Blood Pressure	____Palpitations	____Liver Disease
____Heart Murmur	____History of Rheumatic Fever	____Fever/Chills/Shakes
____Heart Attack	____History of Heart Valve Problems	____Kidney Disease
____High Cholesterol	____Reflux/Gerd	____Thyroid/Adrenal Disease
____Congestive Heart Failure	____Episode of "Black Out"	____Carotid Vascular Disease
___Congenital Heart Problems	____Abnormal Bleeding/Bruising	____Arthritis
____Glaucoma/Cataracts	____Enlarged Heart(Cardiomegaly)	____Emphysema/COPD
____History of Cancer	____Anemia	____Coronary Artery Blockage
____Blood Clots/Varicose Veins	____Hx of Blood Thinners/Clots	____Aneurysm
____PVD (Circulation Problems)	____Heart Rhythm	____Seizures
____Stroke/TIA	____Dementia/Alzheimers	____Asthma

____Chest/Arm/Neck Pain How Often_____ Relieved By_____

____Diabetes: Type I Type II Insulin Dependent: Yes No

Do you take aspirin? Yes No 325mg or 81mg How much? _____ How often? _____

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

Past Surgical History:

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Allergies

Allergic to shellfish? Yes No Allergic to X-Ray dye? Yes No

Medication Allergies

_____

_____

Social & Family History:

Do you smoke? Yes No If Yes, what kind? Tobacco Chew Pipe

How often? _____ How many years? _____ Quit? Yes No If Yes, how long ago? _____

Do you drink alcohol? Yes No How often? _____ How many years? _____

Occupation/Former Occupation: _____ Retired? Yes No

Previous Cardiac Procedures: Where When

Echocardiogram:

_____

Stress Test:

_____

Heart Cath/Stents/CABG:

_____

Pacemaker/Defibrillator:

_____

Other:

_____

Kandarp Patel MD F.A.C.C

Core
Heart & Medical Center

Do you have any of the following:

____Decreased Appetite

____Recent weight loss greater than 5 pounds

____Arthritis, muscle weakness, trouble walking

____Decreased Hearing, Nose Bleeding, Sinus problems, Sore throat

____Stomach ulcers, Colitis, Diverticulitis, Hemorrhoids, dark or bloody stools

____Bronchitis, Tuberculosis, Coughing up blood

____Skin Cancer, Skin rashes, Skin ulcers

Family History of: Heart Disease Cancer Diabetes Stroke High blood pressure

Mother					
Father					
Brother					
Sister					
Son					
Daughter					

Kandarp Patel MD F.A.C.C

Core Heart & Medical Center

MEDICATION LIST

NAME:		DATE:	

Name/phone # of current pharmacy:

MEDICATION NAME	DOSAGE/FREQUENCY/ TIME	DOCTOR	REASON TAKING	REFILL DATE

Medicines allergic to:

Any other notes or comments:

Kandarp Patel MD F.A.C.C

Heart & Medical Center

An Advance Health Care Directive, also called an Advanced Directive, is a legal document stating how you would like to be treated at the end of your life.

In order to complete an Advance Health Care Directive, you must identify the types of treatment you do and/or do not want at the end of your life (Living Will) and name someone who will make sure that your health care decisions are followed (Health Care Proxy or Health Care Power of Attorney).

If you do not have an Advance Directive and would like to complete one, please ask our front desk representative for assistance and they can provide this to you.

ADVANCE DIRECTIVES

Date: _____

I hereby acknowledge that I have been informed of my right to make a decision regarding determination of care. This process known as advance directives has been explained to me. I have shown examples and have been given an information sheet

Check the appropriate statement:

I do not have an advance directive ☐

I have an advance directive ☐

I recognize that it is my responsibility to provide a copy of my advance directive to any and all of my health care providers so that they may accept my wishes.

FIRST NAME (*print*) _____ LAST NAME_____

DATE OF BIRTH: _____

SIGNATURE_____