Younis Cardiology Associates

Registration Form

Date:_____ Referred By:_____

Patient Name:_____Marital Status: ☐ S ☐ M ☐ D ☐ W

Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F

Driver's License Number:_____ State:_____ Social Security Number:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Address:_____City:_____ State:_____ Zip:_____

E-mail Address:_____ Occupation: _____

Employer:_____ Employer Phone:_____

Emergency Contact:_____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

*** Please provide us with your current insurance cards. ***

Circle one: **1**. American Indian/Alaskan Native **2**. Asian **3**. Native Hawaiian **4**. Black/African American **5**. White **6**. Hispanic **7**. Other Pacific Islander **8**. Other Race **9**. Decline to Answer

Assignment of Benefits And Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Younis Cardiology Associates (YCA). I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize YCA to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of this agreement shall be as valid as the original.

Signature:_____ Date:_____

Younis Cardiology Associates
Office Policies

Thank you for choosing Younis Cardiology Associates. We realize you have a choice in selecting cardiovascular care and are honored that you have chosen us. Our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with some information regarding our office policies. Please let us know if you have any questions.

Office Hours
Although appointment times may vary, in general our office staff is available by telephone 8:30 a.m. to 5:00 p.m. Monday through Friday. Outside of scheduled office hours, your calls will be answered by our answering service. In the event your call is an emergency, please call 911 for immediate assistance. If you need to make an appointment, please call during business hours.

Appointments
YCA is committed to providing continuous coverage and quality care to our patients. When calling for an appointment, please let us know your telephone number, physician you are requesting to see, and any updated personal or insurance information. **Kindly notify us of any cancellation within 24 hours of your scheduled appointment so that we may use that time to see other patients.**

Nuclear Stress Tests
Performing a nuclear stress test requires advance preparation including purchase of the necessary radioactive tracer for each patient. If you are unable to make your scheduled nuclear stress test, please notify us at least 24 hours in advance. **Failure to notify us may result in a $300.00 fee to cover the materials purchased in preparation for your test.**

Medical Records
Requests for your medical records must be received in writing. Please contact our office for a form of records release. Also, note that a fee of $25.00 will be assessed for the first 20 pages and $0.15 for each additional page.

Insurance
YCA will be happy to file your insurance claims as a courtesy. **You are responsible to pay, at the time of service, any deductible, co-pay, co-insurance, and any non-covered services**, as stated in your insurance contract. If we are unable to verify your insurance coverage before your appointment, you may either reschedule your visit or be held responsible for all fees accrued on that particular date of service. If your insurance company does not pay your claim within 60 days, the charges will be your responsibility.

Prescription Refills
If you are in need of a prescription refill, please have your pharmacy contact us at least one week before your prescription runs out. Alternatively, you may call our office and leave a message on our refill line. Be sure to include the name of the medication, the pharmacy number, and a number where you can be reached. Refills will be addressed within 24 hours of request. Please be advised that refill requests will be honored in very limited capacity for those patients who have not been seen in more than one year.

_____ _____

Signature of patient or personal representative Date

Younis Cardiology Associates

Patient Acknowledgement of Receipt of Privacy Practices and
Consent/Limited Authorization and Release Form

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.** You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

_____ _____

Please ***print*** your name Patient's Legal Representative

_____ _____

Please ***sign*** your name Description of Authority

MY CONTACT PHONE NUMBERS:

CELL:_____ HOME:_____ WORK:_____ OTHER:_____

EMERGENCY CONTACT: NAME_____ NUMBER(S):_____

PHARMACY NAME_____ ADDRESS_____ PHONE_____

I AUTHORIZE CONTACT FROM THIS OFFICE **TO CONFIRM APPOINTMENTS, TREATMENT, AND BILLING INFORMATION IN THE FOLLOWING SEQUENCE:**

MY PRIMARY PHONE #: (circle one) Cell Home Work Other
SECOND CHOICE #:(circle one) Cell Home Work Other
THIRD CHOICE #:(circle one) Cell Home Work Other

I AUTHORIZE **INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

MY PRIMARY PHONE #: (circle one) Cell Home Work Other
SECOND CHOICE #:(circle one) Cell Home Work Other
THIRD CHOICE #:(circle one) Cell Home Work Other

I AUTHORIZE THIS OFFICE TO **LEAVE A VOICEMAIL WITH DETAILED HEALTHCARE INFORMATION AT:** (circle one) Cell Home Work Other None of the above

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes relatives, friends, and any care takers who can have access to this patient's records and receive test results by phone):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Office Use Only:As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: (circle one) (A) It was emergency treatment (B) I could not communicate with the patient (C) The patient refused to sign (D) The patient was unable to sign because:

_____
Signature of Privacy Officer

YCA New Patient Intake Form

Name:_____

Age:_____Sex:_____ Date:_____

Reason for Visit

☐ Chest pain or pressure ☐ Fainting
☐ Shortness of Breath ☐ Palpitations
☐ Leg/Calf pain with Walking ☐ Abnormal EKG
☐ Abnormal Stress Test ☐ Swelling in Legs
☐ Discomfort in Shoulder/Jaw ☐ Dizziness
☐ High Blood Pressure ☐ High Cholesterol
☐ Other:

Medications

Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency

Family History

Has anyone in your family had these conditions?
☐ Aneurysm ☐ High Cholesterol
☐ Blood Clots ☐ Cardiomyopathy
☐ Heart Attack ☐ Congenital Heart Disease
☐ Stroke ☐ High Blood Pressure
☐ Suddden Cardiac Death ☐ None of the above

Details:

Allergies

List:

Past Medical History

☐ Acid Reflux ☐ HIV
☐ Anemia ☐ Aneurysm
☐ Blood Clot ☐ Artificial Valve
☐ Heart Attack ☐ Stroke
☐ High Cholesterol ☐ Congenital Heart Disease
☐ High Blood Pressure ☐ Arrhythmia
☐ Atrial Fibrillation ☐ Palpitations
☐ COPD ☐ Defibrillator
☐ Cardiac Stents ☐ Cardiac Bypass
☐ Carotid Surgery ☐ Blockages in legs
☐ Diabetes ☐ Pacemaker
☐ Erectile Dysfunction ☐ Kidney disorder
☐ Liver disorder ☐ Obesity Surgery
☐ Radiation Therapy ☐ Others, List:

Hospitalizations and Surgeries

Reason	Date
Reason	Date
Reason	Date
Reason	Date
Reason	Date