777 Commercial St. SE, Suite 130
Salem, Oregon 97301
Office: 503-485-4787
Fax: 503-485-4789
Cascadecardiology.com

Cascade CARDIOLOGY

PATIENT INTAKE

PLEASE FILL OUT COMPLETELY BEFORE YOUR SCHEDULED APPOINTMENT.

Patient Name _____ List any previous/alternate names _____

Mailing Address _____ City _____ State _____ ZIP _____

Physical Address _____ City _____ State _____ ZIP _____

Date of Birth _____ Age _____ Male ❑ Female ❑ Marital Status S ❑ M ❑ D ❑ W ❑ DP ❑ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Veteran? ❑ Yes ❑ No Race _____ Ethnicity _____ Preferred Language _____

Employer _____ Address _____

Spouse Name _____ Parent name _____

Home Phone _____ Cell Phone _____

Emergency Contact _____

Referring Physician _____ Office Phone _____

Primary Care Physician _____ Office Phone _____

Would you be interested in using our online patient portal? ❑ Yes ❑ No E-mail _____

PRIVATE INSURANCE INFORMATION

PRIMARY

Insurance Name _____

Address _____

_____

Subscriber Name _____ ID # _____

Relationship to Patient _____ DOB _____

SECONDARY

Insurance Name _____

Address _____

_____

Subscriber Name _____ ID # _____

Relationship to Patient _____ DOB _____

VOICE MAIL AUTHORIZATION

The purpose of this authorization is to provide our patients an opportunity to permit verbal release of Protected Health Information (PHI). By checking Yes, you authorize Cascade Cardiology, their physicians, physician assistants, medical assistants, administration staff and other personnel to leave detailed messages concerning medical advice, test results, billing and appointment details at the number(s) indicated below.

Authorization: Yes ❑ No ❑ Authorized phone number _____

I hereby authorize Cascade Cardiology to release to the insurance company(s) any information acquired in the course of my examination or treatment. I agree to be fully responsible for all expenses incurred to my account in the course of my treatment and hereby assign to Cascade Cardiology any and all insurance and settlement benefits due me to the full extent of my financial obligation to Cascade Cardiology. I further understand that my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred (If patient is minor, parent or guardian sign). For further detail please reference our company Financial Policy. By signing below I acknowledge receipt of a copy of this notice. I hereby consent to medical treatment per the treatment plan established by my doctor.

Print Name _____

Patient Signature or Authorized Representative _____ Date _____

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MEDICAL HISTORY

Date _____ /_____ / _____

Patient Name _____ Date of Birth _____ /_____ / _____
(Last) (First) (Middle)

SOCIAL HISTORY

Occupation? _____

Marital Status S ❑ M ❑ D ❑ W ❑ DP ❑

Number of children: _____ sons _____ daughters

Exercise? _____ Type? _____ Frequency? _____

Diet: ❑ Regular ❑ Low fat ❑ Low salt ❑ Diabetic ❑ Weight loss
❑ Low carb ❑ Vegetarian ❑ Other _____

Alcohol use? Yes ❑ No ❑ Frequency? _____

Current tobacco use? Yes ❑ No ❑

Type & frequency? _____

Past tobacco use? Yes ❑ No ❑ Quit Date _____

Substance abuse? Yes ❑ No ❑ Quit Date _____

Explain: _____

_____

PHARMACY INFORMATION

Please complete your pharmacy information below as we may be prescribing medications as necessary:

Pharmacy Name _____ Location _____

Phone _____

Do you need assistance with (but not limited to) transfers, restroom use, wheelchair use: Yes ❑ No ❑

If yes, you will need to have an escort that can stay with you throughout your treatment.

FAMILY HISTORY

Family history of Heart Disease? Yes ❑ No ❑ Please specify condition: _____

Age of Family member? _____ ❑ Mother ❑ Father ❑ Brother ❑ Sister ❑ Children ❑ Other (Relation: _____)

ALLERGY & MEDICATION INFORMATION

List Current Medications with DOSAGE and HOW OFTEN you take them (including over the counter medications and creams)

_____

_____

_____

_____

_____

Allergies to medications: Yes ❑ No ❑ List with reaction? _____

Allergies to latex or rubber gloves: Yes ❑ No ❑

Allergies to local anesthesia: Yes ❑ No ❑

Do you take antibiotics before dental work? Yes ❑ No ❑ Why? _____

If female: Are you/do you think you may be pregnant? Yes ❑ No ❑

MEDICAL HISTORY

Have you had any of these problems:

Yes ❑ No ❑ Artificial Heart Valve
Yes ❑ No ❑ Blood Disorders
Type? _____
Yes ❑ No ❑ Bypass
Yes ❑ No ❑ Atrial Fibrillation
Yes ❑ No ❑ Pacemaker/Defibrillator
Yes ❑ No ❑ Diabetes Type 1 or 2? _____
Yes ❑ No ❑ Foot/Ankle Swelling
Yes ❑ No ❑ Heart Murmur
Yes ❑ No ❑ Angiogram/Stents
Yes ❑ No ❑ Previous Cardiac Testing

Yes ❑ No ❑ Hepatitis Type?_____
Yes ❑ No ❑ HIV
Yes ❑ No ❑ High Blood Pressure
Yes ❑ No ❑ High Cholesterol
Yes ❑ No ❑ Irregular Heartbeat
Type?_____
Yes ❑ No ❑ Heart Attack
Yes ❑ No ❑ Stroke/TIA
Yes ❑ No ❑ Thyroid Disorder
Type? _____
Yes ❑ No ❑ Dementia/Alzheimer's

Yes ❑ No ❑ Anemia, bleeding or blood clot problems
Yes ❑ No ❑ Chest pain, wheezing, cough with exercise
Yes ❑ No ❑ Dizziness or fainting with or without exercise
Yes ❑ No ❑ Heart problems
Yes ❑ No ❑ Hospitalization/surgeries
Date _____
Yes ❑ No ❑ Rheumatic fever

Previous Cardiologist: _____ City: _____ State: _____

Previous Hospital: _____ City: _____ State: _____

REVIEW OF SYMPTOMS

Please check any past or present history you have had with the following:

Cardiac:
Yes ❑ No ❑ Chest pain/pressure
Yes ❑ No ❑ Abnormal sweating
Yes ❑ No ❑ Shortness of breath while laying flat
Yes ❑ No ❑ Racing/irregular heartbeats
Yes ❑ No ❑ Fainting

Vascular:
Yes ❑ No ❑ Swelling (ankle/abdominal)
Yes ❑ No ❑ Skin wounds/ulcers (feet/toes slow to heal)
Yes ❑ No ❑ Pain in legs while walking or at rest
Yes ❑ No ❑ Diminished pulses in feet

Constitutional:
Yes ❑ No ❑ Weight gain
Yes ❑ No ❑ Fever
Yes ❑ No ❑ Weight loss
Yes ❑ No ❑ Fatigue

Heent:
Yes ❑ No ❑ Vision changes
Yes ❑ No ❑ Hearing loss

Pulmonary:
Yes ❑ No ❑ Snoring
Yes ❑ No ❑ Shortness of breath
Yes ❑ No ❑ Coughing blood
Yes ❑ No ❑ Wheezing
Yes ❑ No ❑ Tuberculosis, exposure to TB, positive skin test/chest x-ray

Urinary:
Yes ❑ No ❑ Blood in urine
Yes ❑ No ❑ Up at night to urinate

Neurologic:
Yes ❑ No ❑ Dizziness
Yes ❑ No ❑ Seizures
Yes ❑ No ❑ Memory loss

Psychiatric:
Yes ❑ No ❑ Depression
Yes ❑ No ❑ Anxiety

Hematologic:
Yes ❑ No ❑ Acute anemia
Yes ❑ No ❑ Low platelets

Endocrine:
Yes ❑ No ❑ Enlarged thyroid
Yes ❑ No ❑ Tremors

Dermatologic:
Yes ❑ No ❑ Rash
Yes ❑ No ❑ Skin sores

Musculoskeletal:
Yes ❑ No ❑ Joint pain

Other medications or medical history information not included above:

_____

_____

_____

REASON FOR YOUR VISIT

Cardiology concern for todays visit: _____

How long has this been of concern? _____ days _____ weeks _____ months _____ years

Are your symptoms _____ constant _____ intermittent (comes and goes) _____ mild _____ moderate _____ severe

Where are your symptoms located ____ Back/Chest ____ Upper Extremities (Arm) ____ Jaw ____ Other

Do you have a Living Will? Yes ❑ No ❑ If Yes, where is it on file? _____

Print Name _____

Patient Signature or Authorized Representative _____ Date _____

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ACKNOWLEDGEMENT AND CONSENT OF HEALTH INFORMATION

Notice of Privacy Practices

I understand that **Cascade Cardiology,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Permission to release confidential medical information to family members, friends or legal representatives

Print Name: _____ Date of Birth _____

I authorize Cascade Cardiology to release information to: (Please mark all that apply).

Spouse/Significant Other's Name: _____ Phone # _____

☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ **All**
☐ Leave phone messages ☐ Emergency Contact ONLY

Name: _____ Relationship _____ Phone # _____

☐ Discuss information regarding my appointment ☐ Discuss my medical condition ☐ **All**
☐ Leave phone messages ☐ Emergency Contact ONLY

Additional: _____

I understand that I may revoke or change this authorization at any time. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Cascade Cardiology. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

☐ **I do not want information shared with anyone other than myself.** Subject to HIPAA regulations. See above.

By signing below, I agree that I have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices.

Print Name: _____

Patient Signature_____ Date _____

_____ _____

(If unable to sign, patient's Authorized Representative) (Relationship)

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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Birth Date _____

I AUTHORIZE INFORMATION RELEASE ***FROM***:	I AUTHORIZE INFORMATION RELEASE ***TO***:
❑ **ALL** of my other medical providers *~or~*	Cascade Cardiology Name of Facility/Provider
_____ Name of Facility/Provider	777 Commercial St. SE Suite 130 Address
_____ City, State, Zip	Salem, OR 97301 City, State, Zip

Type of Information to be Released

Specific Information Only Please

❑ Chart Notes ❑ Test Results ❑ Last 2 Year History
❑ Laboratory Results ❑ Medication Records ❑ Other: _____
❑ Most Recent Visit ❑ Medical Records from _____ to _____
❑ **All Medical Records**

***Note: If checkbox is not selected, any records your doctor feels necessary for your care will be copied/printed.**

How will the records be released:

❑ Mailed ❑ Faxed ❑ Unsecure Email Email Address: _____

***If records are to be released by way of unsecure email it is important that you understand the risks that are associated with this method of transmission. I have been informed of the risks involved when using unsecure email and I authorize release of the above named records via email.**

Purpose of Release:

❑ Continuing Care ❑ Copies for own use ❑ Legal ❑ Transfer to another provider ❑ Other _____

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS Information
Initials

_____ Mental Health Information
Initials

_____ Drug/Alcohol Diagnosis, Treatment or Referral Information
Initials

_____ Genetic Testing Information
Initials

I understand that the information used of disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that the federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

PATIENT INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. This authorization will expire 1 year from the date signed below unless another date or event is entered here _____. To revoke this authorization, please send a written statement declaring that you are revoking this authorization to: Cascade Cardiology, 777 Commercial St. Suite 130, Salem, OR 97301-0060: Attention: Medical Records.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DATE

_____ _____
PRINT PATIENT'S NAME OR NAME OF PATIENT'S LEGAL REPRESENTATIVE DATE

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FINANCIAL POLICY STATEMENT

We would like to thank you for choosing **Cascade Cardiology** and allowing us to provide your healthcare needs. Policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the lowest cost.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding our financial responsibility and payment policy.

Payment Responsibility

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the time of service. Copays are due at the time of service. Payment will be accepted in cash, checks, Visa, Discover, MasterCard & Amex. Patients needing to make payment arrangements will be referred to the Billing Office for the necessary arrangements.

The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangements for payments will be made at the clinic's discretion based on the amount. It is your responsibility to understand your benefit plan.

Release of Information

By signing our Acknowledgement of Consent form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers. Medical and billing records will be on file with **Cascade Cardiology** for a minimum of seven years. When requesting medical records, please allow up to 30 days for release of information. Charges may apply to certain parties as allowed by Oregon law.

Patient Responsibility

Balances after insurance are due within 30 days of the insurance payment, unless other arrangements have been made with the Billing Department, the financial counselors of the clinic.

Statements are sent out on a monthly basis and it is required by the clinic that balances be paid within 30 days of the statement date. Past due accounts which have not contacted our office to set up payment arrangements may be sent to an outside collection agency for account receivable assistance. In cases where suit needs to be filed in order to recover a past-due balance, all court costs and attorney's fees will be borne by the patient/guarantor.

All services may not be covered by all insurance companies. It should be understood that by accepting the service(s), the patient/guarantor is responsible for payment regardless of the insurance coverage.

Checks returned for Non Sufficient Funds (NSF) are subject to a reprocessing fee of $15.00.

Uninsured Patients

If you are not covered by insurance, our clinic policy requires a $300.00 deposit at the time of your first visit. If you are scheduled for a hospital follow-up our clinic policy requires a $173.00 deposit. This deposit will be applied to the total cost of your visit. Please contact the Billing Department to make payment arrangements on any outstanding amounts. Subsequent appointments cannot be scheduled until you have payment arrangements in effect.

Out of Network Patients

If the clinic is not an in-network provider with your insurance company you may still have out of network benefits that would allow you to be seen. In the event that your insurance carriers pays you directly for services preformed at **Cascade Cardiology** you're required to turn over the check to our office within 7 days of receipt.

Outstanding Bills

The clinic reserves the right to request deposits and payment for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed. The clinic will make every effort to work with the patient on creating the appropriate payment plan if needed.

If the account is not paid in full or payment and/or payment arrangements haven't been made within the allowed time frames, the clinic reserves the right to refer the account to an attorney and/or collection agency for collection of the balance.

Patient Scheduling

Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic's Financial Policy on the first initial visit. By signing the bottom of the Financial Policy at the initial appointment the patient/guarantor acknowledges receipt of copy of the clinic's Financial Policy.

Attendance Policy

If you should need to cancel or re-schedule any appointment please call the office at least 48 hours in advance. If you miss an appointment and fail to contact our office as described above, you will be charged a fee of $25.00. If you arrive more than 15 minutes late for your appointment we reserve the right to cancel your appointment. If you repeatedly miss or reschedule your appointment, you may be referred back to your PCP. The first time there is a "no-show" there will be no charge to the patient. A 2nd occurrence will result in a $25 fee. The 3rd occurrence will be the $25 fee and the patient may be discharged from the practice.

Acceptance of Insurance

The clinic will submit a bill to the insurance carrier(s) on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient/guarantor of financial responsibility. The patient/guarantor will be responsible for payment in full on all claims not paid within the allowed period of time (see patient responsibility). The clinic will make every effort to verify insurance coverage, deductible, acceptance of payment for services and other limits for the patient as a courtesy.

Pre-Certification

The clinic will make every effort to pre-certify and/or obtain written referral for all services and procedures that are required, provided the clinic is supplied with the necessary and correct information. In addition, the clinic will make every effort to certify ongoing authorization and referrals as needed. It is however, the responsibility of the patient to verify that all authorization and referrals are on file and have been approved by the insurance company.

Rejected Claims/Services Not Covered

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available and we will make every effort in helping get your claims and services covered, we cannot act as a mediator on your behalf.

The Administration and Management welcomes the opportunity to discuss any aspect of the Financial Policy. We appreciate your confidence and strive to provide you with the best quality healthcare.

I have read the **Cascade Cardiology** Financial Policy Statement and agree to the payment policies and understand my patient responsibilities.

Print Name

Signature of Patient or Authorized Representative

Date: Date of birth: SSN: