

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



# 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

### SECONDARY

Insurance Name \_\_\_\_\_ Insurance Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ ID # \_\_\_\_\_ Subscriber Name \_\_\_\_\_ ID # \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_ 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 \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Last) (First) (Middle)

## SOCIAL HISTORY

Occupation? \_\_\_\_\_ Alcohol use? Yes  No  Frequency? \_\_\_\_\_  
Marital Status S  M  D  W  DP  Current tobacco use? Yes  No   
Number of children: \_\_\_\_ sons \_\_\_\_ daughters Type & frequency? \_\_\_\_\_  
Exercise? \_\_\_\_\_ Type? \_\_\_\_\_ Frequency? \_\_\_\_\_ Past tobacco use? Yes  No  Quit Date \_\_\_\_\_  
Diet:  Regular  Low fat  Low salt  Diabetic  Weight loss Substance abuse? Yes  No  Quit Date \_\_\_\_\_  
 Low carb  Vegetarian  Other \_\_\_\_\_ 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 \_\_\_\_\_



## 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 # \_\_\_\_\_

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Discuss information regarding my appointment | <input type="checkbox"/> Discuss my medical condition | <input type="checkbox"/> <b>All</b> |
| <input type="checkbox"/> Leave phone messages                         | <input type="checkbox"/> Emergency Contact ONLY       |                                     |

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Discuss information regarding my appointment | <input type="checkbox"/> Discuss my medical condition | <input type="checkbox"/> <b>All</b> |
| <input type="checkbox"/> Leave phone messages                         | <input type="checkbox"/> 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)



**AUTHORIZATION TO USE/DISCLOSE  
PROTECTED HEALTH INFORMATION**

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I AUTHORIZE INFORMATION RELEASE **FROM:**

**ALL** of my other medical providers  
~or~

\_\_\_\_\_  
Name of Facility/Provider

\_\_\_\_\_  
City, State, Zip

I AUTHORIZE INFORMATION RELEASE **TO:**

Cascade Cardiology

\_\_\_\_\_  
Name of Facility/Provider

777 Commercial St. SE Suite 130

\_\_\_\_\_  
Address

Salem, OR 97301

\_\_\_\_\_  
City, State, Zip

**Type of Information to be Released**

**Specific Information Only Please**

- Chart Notes
- Laboratory Results
- Most Recent Visit
- All Medical Records
- Test Results
- Medication Records
- Medical Records from \_\_\_\_\_ to \_\_\_\_\_
- Last 2 Year History
- Other: \_\_\_\_\_

**\*\*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



## 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: