PATIENT REGISTRATION

Please fill out forms as completely as possible, and bring in with you to your appointment. If you have questions please call or ask the receptionist at check in

Last Name: ______________________ First: ______________________ Middle Initial: ________

Mailing Address: ____
City State Zip

Physical Address: ____
City State Zip

Home Phone #: ____________________ Work Phone #: ____________________ Veteran? Y N

Cell Phone #: ____________________ E-mail: ______________________________

DOB: ____________________ Sex: M F Social Security #: ____________________

Primary Care Physician: ______________________________Phone #: ____________________

Who Referred You to our Practice? ____

Employer Name: ______________________________Phone #: ____________________

Employer Address: ____
City State Zip

Spouse/Significant Other's Name: ______________________________ Phone #: ____________________

I authorize Cascade Cardiology to release my information to my spouse/significant other:

□ Discuss information regarding my appointment □ Discuss my medical Condition □ **ALL**
□ Leave phone messages □ Emergency Contact ONLY

Please mark the box below if you do not want your information discussed with your spouse/significant other:

□ ***I understand that by marking this box, my spouse/significant other will not be given any information regarding my medical condition, appointments or financial account. I also understand that I may change this authorization at any time with written notice.***

Is patient a MINOR? _____ If YES, Responsible Person's Name: (PLEASE PRINT): ______________________________

Relationship to patient: ______________________________ Phone #: ____________________

I hereby authorize Cascade Cardiology to speak with the above person regarding my account.

SIGN: ______________________________ Date: ____________________

I consent to treatment necessary for the care of the above named patient or myself. I authorize the release of all medical records/information to the referring, referred and/or family physician. I authorize the health care providers of Cascade Cardiology, LLC. (CC) to release my medical information that is needed to determine insurance benefits or benefits payable to the Heath Care Finance Administration and its agents. I hereby assign to CC, all monies to be paid by said insurance company for services provided by CC, but not to exceed my indebtedness to said clinic. ***I understand and agree that the health insurance policies are an arrangement between the insurance carrier and me. I acknowledge that I am financially responsible for the deductible and co-pay. I also understand that any unpaid balances are my responsibility and any overdue balances may result in a finance charge and/or being assigned to a collection agency.***

______________________________ ______________________________ ____________
Print Patient's Name Responsible Party Signature Date

PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO FAMILY MEMBERS, FRIENDS OR LEGAL REPRESENTATIVES

IMPORTANT NOTICE: The law prohibits release of confidential medical information to any entity without the written, voluntary consent of the undersigned patient.

Patient Name: ____ Date of Birth: _________________________

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

Name: ______________________________ Relationship: ____________________ 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

Name: ______________________________ Relationship: ____________________ 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

□ **I do not want information given out to anyone other than myself.**

I understand this authorization form gives the person(s) listed above permission to verbally access the information specified.

I understand that by marking "I do not want information given out to anyone other than myself," no friend, family member or legal representative will have access to my medical information, including questions regarding my upcoming appointments, financial account and medical condition.

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.

Signature of Patient: ____ Date: ____________________

Signature of Legal Representative: ____ Date: ____________________

*** This authorization does not pertain to written records***

CASCADE CARDIOLOGY, LLC.

HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that Cascade Cardiology (referred to below as "CC") 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 CC 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 (including Medicare) 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. Our Notice of Privacy Practices is also available at our website: cascadecardiology.com. 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 CC is not required by law to agree to such requests. I authorize my personal medical information to be released to my:

Primary Phone: ______________________________________OK to leave confidential info? Yes ☐ No ☐

Secondary Phone: ____________________________________OK to leave confidential info? Yes ☐ No ☐

Primary Insurance: ____

Secondary Insurance: ____

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

Patient Name: ____ DOB: ______________________

Signature: ____ Date: ______________________

By: ____ Date: ______________________

(Patient Representative)

Patient Questionnaire

DATE: _______/_______/_______

NAME: ____ DATE OF BIRTH: _______/_______/_______

MARITAL STATUS: _________________ NUMBER OF CHILDREN _____ SONS _____ DAUGHTERS _____

OCCUPATION: ____

DIET: REGULAR: _____ LOW FAT/CHOL: _____ LOW SALT: _____ DIABETIC: _____ RENAL: _____
NO ADDED SALT: _____ WEIGHT LOSS: _____ LOW CARB: _____ VEGETARIAN: _____

SMOKING STATUS (PLEASE CIRCLE ONE): CURRENT SMOKER FORMER SMOKER (QUIT DATE: _________) NEVER

ALCOHOL USE: ___________________ RARELY: _____ SOCIAL: _____ DAILY: _____ FREQUENT: ___________

EXERCISE: ______ TYPE: _________________________ FREQUENCY: _____________________________________

YOUR PHARMACY:____

LOCATION / CROSS STREET / CITY: ____

FAMILY HISTORY OF HEART DISEASE: ____

MEDICATIONS AND DOSAGES (PRESCRIPTION AND OVER THE COUNTER) YOU ARE CURRENTLY TAKING:

1.____________________________ 4.____________________________ 7.____________________________

2.____________________________ 5.____________________________ 8.____________________________

3.____________________________ 6.____________________________ 9.____________________________

ALLERGIES: ____

PLEASE CHECK ANY PAST OR PRESENT HISTORY YOU HAVE HAD WITH THE FOLLOWING:

CARDIAC:

Y	N		Y	N	
___	___	CHEST PAIN /PRESSURE	___	___	RACING/IRREGULAR HEART BEATS
___	___	ABNORMAL SWEATING	___	___	FAINTING
___	___	SHORTNESS OF BREATH WHILE LAYING FLAT			

VASCULAR:

Y	N		Y	N	
___	___	SWELLING (ankle/abdominal)	___	___	PAIN IN LEGS WHILE WALKING OR AT REST
___	___	SKIN WOUNDS/ULCERS (feet/toes slow to heal)	___	___	DIMINISHED PULSES IN FEET

CONSTITUTIONAL:

Y	N		Y	N	
___	___	WEIGHT GAIN	___	___	WEIGHT LOSS
___	___	FEVER	___	___	FATIGUE

HEENT:

Y	N		Y	N	
___	___	VISION CHANGES	___	___	HEARING LOSS

PULMONARY:

Y	N		Y	N	
___	___	SNORING	___	___	COUGHING BLOOD
___	___	SHORTNESS OF BREATH	___	___	WHEEZING

URINARY:

Y	N		Y	N	
___	___	BLOOD IN URINE	___	___	UP AT NIGHT TO URINATE

NEUROLOGIC:

Y	N		Y	N	
___	___	DIZZINESS	___	___	MEMORY LOSS
___	___	SEIZURES			

PSYCHIATRIC:

Y	N		Y	N	
___	___	DEPRESSION	___	___	ANXIETY

HEMATOLOGIC:

Y	N		Y	N	
___	___	ACUTE ANEMIA	___	___	LOW PLATELETS

ENDOCRINE:

Y	N		Y	N	
___	___	ENLARGED THYROID	___	___	TREMORS

DERMATOLOGIC:

Y	N		Y	N	
___	___	RASH	___	___	SKIN SORES

MUSCULOSKELETAL:

Y	N		Y	N	
___	___	JOINT PAIN	___	___	MUSCLE ACHES

OTHER MEDICATIONS OR MEDICAL HISTORY INFORMATION NOT INCLUDED ABOVE:

____

____

____

____

PATIENT SIGNATURE: **DATE**:

Maziar Azadpour, MD, FACC, FSCAI
Harminder P. Gandhok, MD, FACC, FSCAI
Ashit G. Patel, MD, FACC, FHRS
Kirk W. Walker, MD, FACC, FSCAI

Sharon M. Dickinson, PA-C, AACC
Laura C. Mason, PA-C
Odessa Steigleder, PA-C
Heather M. McLean, FNP-C

Name: ______________________________________ Date of Birth: ______________________

Cascade Cardiology is dedicated to providing patients with excellent cardiac care. Please complete this history questionnaire regarding previous care including ***dates of service*** and ***facility names*** so we can accurately obtain your records for your upcoming appointment.

If you have any questions, please feel free to contact our office at 503-485-4787.

- ❖ Have you ever had cardiac bypass surgery or valve replacement? If so, when and where?
- ❖ Have you ever had a cardiac catherization, angiogram, or stent? If so, when and where?
- ❖ Do you have a pacemaker or defibrillator implanted? If so, when and where?
- ❖ Have you ever been to the emergency room for chest pain, shortness of breath, etc.? If so, when and where?
- ❖ Have you ever had any cardiac diagnostic testing done? For example, EKGs, echocardiograms, stress test, nuclear studies, etc.? If so, when and where? Please list contact number.
- ❖ If you have ever seen a cardiologist, please list the name of the cardiologist, doctor's contact number, city and state of practice, and date last seen.

Thank you for assisting us in our efforts to provide you with the best care possible!

Please mail this form with the attached Release of Information prior to your upcoming appointment.

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____ Birth Date: ______________________________

I AUTHORIZE INFORMATION RELEASE ***FROM***:	INFORMATION TO BE RELEASED ***TO***:
______________________________ Name of Facility/Provider	Cascade Cardiology Name of Facility/Provider
______________________________ Address	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.***

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. 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