For Office Use Only
Verified Date: _____
By: _____
System Account#: _____
Date/By: _____

How did you hear about HeartPlace?
❑ Physician Referral ❑ Advertisement
❑ Friend ❑ Other: Please Specify _____ Date: _____

Patient Information

Name: _____ Doctor: _____
last first middle

Social Security #: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

❑ Married ❑ Single ❑ Widow ❑ Divorced Age: _____ Date of Birth: _____ ❑ Male ❑ Female

Employer Name: _____ Employer Address: _____

❑ Full-Time ❑ Part-Time ❑ Retired ❑ Self-Employed ❑ Student Full-Time ❑ Student Part-Time

Referring Physician: _____ Referring Physician Ph.: (____) _____

Primary Care Physician: _____ Primary Care Physician Ph.: (____) _____

Insured Name (If no insurance, responsible party)

Name: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

Employer Name: _____ Employer Address: _____

Notify In Case of Emergency

1. Name: _____ Relationship: _____ Home Ph.: (____) _____ Business Ph.: (____) _____

2. Name: _____ Relationship: _____ Home Ph.: (____) _____ Business Ph.: (____) _____

Insurance Information – Copies of Insurance Cards and Drivers License are Required

Insurance 1: _____

Address: _____ Phone: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Insurance 2: _____

Address: _____ Phone: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Authorizations

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the reciept of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed _____ Date _____

Patient Name (Please Print) _____

Witness Signature _____ Date _____

HEARTPLACE PATIENT PRIVACY NOTICE SUMMARY

Protecting your confidential health information is important to us. Certain federal law referred to as "**HIPAA**" protects the confidentiality of your health information (generally referred to as "**Protected Health Information**" or "**PHI**"), and we take it seriously. This summary of our **Notice of Privacy Practices** ("**Notice"** or **"Privacy Notice")** has been prepared to provide you with a brief description of certain of the key provisions of the Notice regarding how medical and other personal information about you may be used or disclosed, and how you may obtain access to your information and its disclosure. For a more complete description of our privacy practices under HIPAA, please refer to the attached Notice.

What is Protected Health Information (PHI)?

PHI is information created or received by HeartPlace and transmitted or maintained in written, electronic or any other form, that relates to your past, present or future health condition, the provision of healthcare to you, and/or information about payment for the provision of your healthcare, and, which may identify you or could reasonably be used to identify you.

How may my PHI be used or disclosed?

HeartPlace may use or disclose your PHI to carry out your **'Treatment'** (provision, coordination or management of your healthcare or related services), **'Payment'** (obtain payment for your healthcare services, including activities that may be required by your insurer(s) to obtain approval for payment), or for other **'Health Care Operations'** (other functions that HeartPlace performs in connection with providing health care, i.e., quality assessments, training of medical students, credentialing, auditing and financial reporting). Use or disclosure of your PHI pursuant to the Notice may include electronic transmittal or disclosure. HeartPlace also sends PHI to a Health Information Exchange (HIE) to allow for information exchange for information that may be relevant to your future care i.e. in an emergency situation participating facilities and physicians can access your information for your treatment. In addition, your prior prescription information will be obtained through SureScripts to assist us in providing you treatment. You can opt out of the HIE and of SureScripts by completing the appropriate forms available when you ask your HeartPlace office staff.

When might HeartPlace use or disclose my PHI without my authorization?

HeartPlace is not required to obtain your authorization or notify you when it uses or discloses your PHI for your treatment, to obtain payment, or for other health care operations as discussed above. In addition, there are some limited exceptions where the law allows your PHI to be used to promote the Government's need to ensure a safe and healthy society. In some cases, you may be given an opportunity to agree or object before the use or disclosure of your PHI. In all cases, HeartPlace will make every effort to ensure that it meets necessary prerequisites and will not use or disclose your PHI more than is permitted under the law.

What Are My Rights Under the HIPAA Privacy Standards?

Patients have certain rights under the HIPAA Privacy Standards, subject to certain limitations:

- You have the right to request restrictions on certain uses and disclosures of your PHI by HeartPlace.
- You have the right to request that we communicate with you in a certain way. We make every effort to honor your reasonable requests for confidential communication.
- You have the right to read, review and receive copies of your health information.
- You have the right to request and obtain an accounting of disclosures HeartPlace has made of your PHI.
- You have the right to request an amendment to your PHI. *(HeartPlace reserves the right to deny requests to amend PHI. For example, if the information is accurate, or if the information was not created or is not maintained by HeartPlace.)*
- You have the right to request a copy of the Privacy Notice.
- You have the right to file a complaint if you believe that HeartPlace has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules.

HEARTPLACE PRIVACY OFFICER

HeartPlace has procedures in place for receiving and resolving HIPAA-related complaints, and, handling other HIPAA and PHI requests and concerns. Such issues are handled by the **HeartPlace Privacy Officer**. You may:

- Request additional restrictions for release of your PHI
- Change restrictions/change contact information
- Request an amendment to your health record
- Request copies of the Notice
- Resolve your complaints *(complaints must be directed in writing to the Privacy Officer).*

Contact the HeartPlace Privacy Officer:
By Mail: HeartPlace, Attn: Privacy Officer, 16980 Dallas Parkway, Suite 200 Dallas, TX 75248
By Phone: (972) 391- 1900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the **HeartPlace Notice Privacy Practices**.

_____ _____/_____/_____
Patient Name (Print) Date of Birth

_____ _____/_____/_____
Patient Signature Date of Acknowledgement

RELEASE OF HEALTH INFORMATION

PRIMARY CARE PHYSICIAN (PCP): _____

Address of PCP: _____

❑ HeartPlace **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws.

❑ HeartPlace **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that if I would like to authorize HeartPlace to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

_____ _____ _____/_____/_____

Patient Name (Please Print) Patient Signature Date

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

❑ No Expiration
❑ Date of Expiration _____/_____/_____
❑ Event: (Describe event upon which this Authorization will expire) _____

PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:

❑ Phone #: (_____) _____ - _____
❑ OK to leave message with detailed information
❑ OK to leave message with contact number only
❑ DO NOT LEAVE MESSAGE

All normal test results will be sent via our **Patient Portal** to **Email**: (PLEASE PRINT)

_____ @ _____ . _____

Appointment reminders:

❑ Text [# if different than above (_____) _____ -_____]
❑ Phone
❑ Email

AUTHORIZATION FOR ACCESS AND USE OF SURESCRIPTS PRESCRIPTION HISTORY

HeartPlace, with your authorization, has the ability to import the last 16 months of your prescription history directly from the Surescripts E-prescribing database. Surescripts is used by most pharmacies and insurance companies to process prescriptions. If you paid cash or did not pickup a prescription, it will not be in the Surescripts database.

The import of Surescripts prescription history is not required for treatment. HeartPlace understands there may be situations, prescriptions, and medical history you do not want to share with your physician. Notifying your physician of all your medical history and currently prescribed medications is critical for proper care.

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") by Surescripts and the access and use of that information by HeartPlace, P.A. ("HeartPlace").

Patient's Name: _____ **Date of Birth:** _____

Name of organization(s) authorized to access, use or receive the Protected Health Information: **Surescripts and HeartPlace.** Specific description of Protected Health Information to be accessed, used or disclosed: Prescription drug information, including patient medication history data, maintained in the Surescripts electronic prescription data system.

Event on which this Authorization will expire: **One year**

I understand that I may refuse to sign this Authorization, and that my health care treatment will not be conditioned upon signing this form. I also understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace or Surescripts took before it received the revocation of this Authorization. I understand that I may see and copy the Protected Health Information described on this Authorization, if I request to do so in writing. I understand that I will receive a copy of this Authorization after I sign it.

Will HeartPlace or any of its providers receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes___ No__X_**

_____ _____
Signature of individual or individual's representative Date

_____ _____
Printed name of individual's representative Relationship to patient

_____ _____
Witness Date

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

www.heartplace.com

NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH:_____ DATE OF VISIT:_____
PRIMARY CARE PHYSICIAN: _____
OTHER PHYSICIANS (THAT YOU WISH TO RECEIVE RECORDS):_____

1. **Reason for visit**:
   - ☐ Main complaint or concern (specify): _____
   - ☐ Establish Cardiovascular Care / Risk Assessment

2. **Care Team – please identify**
   a. Primary Care Provider_____
   b. Other physicians that need to receive your cardiovascular care records
      _____

3. **Allergies (specify substance and reaction):**
   _____

4. **Medications (specify dose, frequency; include over-the-counter, supplements)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. **Heart/Vascular History**: *check and if applicable specify date / detail*

CONDITION	YES	NO	DATE/DETAIL
High Blood Pressure			
High Cholesterol			
Diabetes			
Congenital Heart Disease (heart defect at birth)			
Rheumatic Fever			

CONDITION	YES	NO	DATE/DETAIL
Coronary Artery Disease (blocked heart artery)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure (weak heart and/or fluid in lungs)			
Valvular Heart Disease (blocked or leaky valves)			
Arrhythmia (ie: afib)			
Cardiac Surgery / Procedure			
Cerebrovascular Disease (stroke, carotid blockage)			
Peripheral Vascular Disease (leg or arm blockage)			
Aneurysm			
Deep Vein Thrombosis / Pulmonary Embolism (leg / lung clots)			
Vascular Surgery / Procedure			

6. **Family History**: do your parents and/or siblings have heart and/or vascular disease? If so please specify the problem and age it started:
   Father:_____
   Mother:_____
   Sibling(s):_____

7. **Lifestyle:**
   a. **Have you ever smoked?** (if yes, specify how much and for how many long):
      _____
   b. **Do you drink alcohol?** (if yes, specify how much and how frequently):
      _____
   c. **Do you use drugs?** (if yes, specify type and how frequently):
      _____

8. **Occupation:** _____

9. **Marital status:**
   - ☐ Single
   - ☐ Married
   - ☐ Widowed
   - ☐ Divorced

10. **Residence: with whom do you live?**
    - ☐ Spouse
    - ☐ Alone
    - ☐ Other (please specify): _____

11. **Education Level:** (specify highest level): _____

12. **Children:** (specify number, age(s)): _____

13. **Surgeries:** (specify prior operations/surgeries with date):

_____
_____
_____
_____
_____

14. **Prior Testing:** (if applicable)

Last / Prior Stress Test	Date: _____
Last / Prior Echocardiogram (ultrasound)	Date: _____
Last / Prior Cardiac Catheterization	Date: _____

15. **Other Past Medical History:**
    Please list ***other (non-cardiac/vascular)*** medical problems not identified above:

_____
_____
_____
_____
_____
_____
_____
_____
_____

16. Are you experiencing or have you recently experienced any of the following?

- ☐ Activity Change
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Vision change
- ☐ Snoring
- ☐ Room spinning (vertigo)
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath at rest
- ☐ Shortness of breath on exertion
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Chest pain/discomfort
- ☐ Sweating
- ☐ Palpitations (racing/irregular heart beat)
- ☐ Shortness of breath lying flat
- ☐ Wake up short of breath
- ☐ Passing out / Loss of consciousness
- ☐ Near passing out / near fainting
- ☐ Leg swelling
- ☐ Varicose veins
- ☐ Pain in the legs
- ☐ Leg/foot ulcer/wound
- ☐ Vomiting blood
- ☐ Blood in the stool
- ☐ Acid reflux (heart burn)
- ☐ Blood in the urine
- ☐ Difficulty urinating
- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Skin sore or ulcer
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Easy bleeding
- ☐ Temperature intolerance (hot or cold)
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Tremor(s)
- ☐ Depression
- ☐ Anxiety
- ☐ Increased stress
- ☐ Dizziness
- ☐ Seizures
- ☐ Memory loss
- ☐ Drooping of the face
- ☐ Difficulty with balance
- ☐ Confusion
- ☐ Paralysis
- ☐ Numbness of limbs
- ☐ Slurred speech

HeartPlace
The Future Of Cardiology Is Here

Patient Questionnaire
Are you at risk for Peripheral Artery Disease?

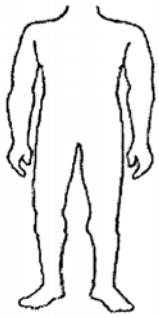
Name:_____ Date:_____

Peripheral artery disease (PAD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged. Please fill out this questionnaire to see if you have symptoms of Peripheral Artery Disease. Circle Yes or No to the following questions:

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks? **Yes** **No**

2. If you answered yes, does the pain subside with rest? **Yes** **No**

   If applicable, circle the area of the body on the diagram below where you feel pain:



3. Do you have any painful sores or ulcers on your legs or feet that aren't healing? **Yes** **No**

4. Do you have (circle all that apply):

   Diabetes High Cholesterol History of Smoking High Blood Pressure

If you have answered yes to any of the above you may be at risk for PAD.

PHYSICIAN ONLY:

☐ Lower Extremity Arterial Duplex (ABI) ☐ CTA

☐ Vascular Consult ☐ Patient Not A Candidate For Further Screening

ICD Codes:
Claudication unspec..PVD 443.9
PVD unspec. 443.9
Ulceration athero. of extr. 440.23
Claudication intermittent with Atherosclerosis 440.21
Athero. of Aorta 440.0
Rest pain athero. of extremities 440.22

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEARTPLACE

TO: _____

1. I hereby consent to the release and transfer to:

HeartPlace

_____

_____

the following information from its records on:

_____

(Patient's Name)

_____ _____

Birth Date Social Security Number

SPECIFY INFORMATION: _____

_____

2. The above information is released for the following purpose and that purpose only. **Other uses are prohibited.**

_____

3. I understand that the specific information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data.

4. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace too, including any uses or disclosures of my Protected Health Information made by HeartPlace, before it received the revocation of this Authorization.

5. I understand that if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

6. I understand that I have a right to inspect and copy my own Protected Health Information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

7. I authorize faxing the information to be disclosed to the requesting party ☐ yes ☐ no

8. I have read and understand this consent and I have signed it voluntarily and of my own free will.

9. This authorization will expire ninety (90) days from the date of signature.

_____ _____

Signature of Patient Witness

_____ _____

Specify relationship (legal & authorization where applicable) Witness

_____ _____

Date Date

Prohibition of Re-disclosure: This information has been disclosed to you from records which are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.