Thomas A. Mattioni, MD
David W. Riggio, MD
Michael S. Zawaneh, MD
Sushmitha Patibandla, MD
Junaid Bhutto, MD

Jaime M. Stempihar, PA-C
Heather M. Ross, DNP, ANP-BC
Jayna S. Ling, AGPCNP-BC

Dear Valued Patient,

We would like to thank you for choosing Arizona Arrhythmia Consultants for your Electrophysiology needs. The following information is provided to help you have the best experience possible at your appointment.

- **New Patient Packet:** All new patients need to complete the attached forms and bring them to their visit.
  - Patient Demographic
  - Consents form
    - HIPAA
    - Authorization of Release of Health Information
    - Financial Policy
    - Patient Portal Authorization
  - Cancellation and No Show Policy
  - Medical History
- **Items To Bring To Your Appointment:**
  - Current insurance card(s)
  - Driver's license
  - Current medication list
- **Late Arrival Policy:** If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule your appointment(s).
- **All Appointments:** Failure to cancel any appointments within 24 hours of your appointment will result in a $25.00 charge added to your account.
- **Copay, Co-Insurance, and Account Balance Payments:** Please be prepared to pay your co-payments, and/or any outstanding balances which are due at the time of your visit. Please refer to the Financial Policy for your financial obligations as a patient.
- **Check-out Process:** At this time you will schedule any follow up and/or device appointments ordered by the providers or device clinic.
- **Communication:** Following your visit, there are several methods to reach a member of our office staff.
  - **Telephone:** to minimize your wait time on the phone, please follow these instructions:
    - Use the voicemail option to avoid long wait times
    - The following selections will be offered when you call in to expedite your call:
      - Option 2 – Scheduling
        - Option 1 – To schedule/reschedule an office appointment
        - Option 2 - to schedule/reschedule a hospital procedure
      - Option 4 – Clinical Staff
        - Option 1 – Urgent line
        - Option 2 – Medical Assistants
          - Option 1 – Sharon, MA for Dr. Mattioni

            - Option 2 – Don, MA for Dr. Riggio, Dr. Bhutto & Jayna Ling, NP
            - Option 4 – Ana, MA for Dr. Patibandla
            - Option 5 – Jim, MA for Dr. Zawaneh & Jaime Stempihar, PA
            - Option 6 – Melanie, MA for Heather Ross, NP
        - Option 4 – Device Department
            - Option 1 – Sam, Device Clinic Administrative Assistant, remote monitoring questions
            - Options 2 –Brenda Nolan, Device Technician for non-urgent device related issues/concerns
        - Option 5 – Prescription Refill
    - Option 5 – Billing Department
        - Option 1 – Mindy, Referrals & Authorizations
        - Option 2 – Mindy, Insurance questions/concerns
        - Option 3 - Billing Department, for questions about or to pay your bill or any other billing questions/concerns
- **Patient Portal: -** www.NextMD.com
    - This is secure website for patients to communicate with our practice, request appointments and medical records, receive remote device reports, etc.
    - **This is our preferred method of communication with patients**, so please ask a member of our staff for a token number and register for the Patient Portal as soon as possible.

Again, we thank you for choosing Arizona Arrhythmia Consultants for your Electrophysiology care. We look forward to meeting you!

Arizona Arrhythmia Consultants, PLC
3225 N Civic Center Plaza, Suite 1, Scottsdale, AZ 85251
10117 N 92nd Street, Suite 103, Scottsdale, AZ 85258
3185 N Windsong Drive, Prescott Valley, AZ 86314
Phone: 480-246-3000
Fax: 480-246-3100

www.AACHeart.com

Patient Demographics

Last Name ______________________First Name _________________Middle Initial _______________
SSN______________________ DOB _____________________ Sex: (Please circle) M F
Address ______________________________________ City/State/Zip _________________________

Race (i.e. Caucasian/Hispanic/Asian) ____

Primary Language ____

Marital Status (Please circle) Single Married Widowed Divorced Other ____________________

How may we contact you? (Please circle) Home Phone Cell Phone Email Address

May we leave you a detailed message (Please circle) Yes No

Home Phone ____________________ Cell Phone ________________________ Other ____________

Email Address:

Primary Care Provider ____ Phone ________________

Referring Provider/Cardiologist __________________________________ Phone _________________

Primary Insurance Name ____

Primary Insurance Holder Name _____________________DOB _________Relationship_____________

Secondary Insurance Name ____

Secondary Insurance Holder Name __________________ DOB ________ Relationship _____________

Acknowledgment of Accuracy:
I have reviewed my personal information for accuracy. I have changed any information that is incorrect. I accept all financial responsibility that may be incurred as a result of submitting incorrect information.

____
Signature of Patient/Guardian Date

ARIZONA ARRHYTHMIA CONSULTANTS™

Consents form

Patient Name: ____________________________ Date of Birth: _____________________________

Do you have an Advance Directive? Yes ☐ No ☐
(An Advanced Directive is a legal document expressing your critical care wishes when you are unable to decide for yourself)

Acknowledgement of Notice of Privacy Practices:
I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Arrhythmia Consultants has the right to change its Notice of Privacy Practices at any time and that I may contact Arizona Arrhythmia Consultants at any time to obtain a current copy.

Signature: ________________________________ Date: ___________________________________

Authorization of Release of Health Information:
I authorize the following individual(s) to have access to my personal health information.

Name: __________________________ Relationship: ___________________ Phone: _________________
Name: __________________________ Relationship: ___________________ Phone: _________________
Name: __________________________ Relationship: ___________________ Phone: _________________

Signature: ________________________________ Date: ___________________________________

Acceptance of Payment Policy and Patient Financial Agreement:
I have read, understand, and agree to the provisions of the Payment Policy and Patient Financial Agreement.

Signature: ________________________________ Date: ___________________________________

Acceptance of Patient Portal Authorization:
By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Agreement.

Email Address:

Signature: _____________________________________ Date: ______________________________________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must miss your appointment. It is therefore requested that if you must miss your appointment you provide the office with more than a 24 hours' notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than a 24 hours' notice, we are unable to offer that appointment to other patients.

Office appointments which are cancelled with less than a 24 hours notification, will be subject to a **$25.00** cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a **$150.00** cancellation fee. Any appointments that are not cancelled within 24 hours will be considered a no-show at the time of your appointment and will be charged the cancellation fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that some unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval, once per 12 month period.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department Manager at (480) 246-3070.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

____ ________________________

Printed Patient Name Date of Birth

____ ________________________

Patient Signature Date

Last Updated: 12/12/2016

Medical History

Name ______________________________ DOB _________________ Age _____________
Current or previous occupation ____________________________________ Retired Y or N
Marital Status: Single Married Separated Divorced Widowed Name of Spouse _____________
Race (i.e. Caucasian/Hispanic/Asian) ____
Ethnicity (i.e. American/Hispanic/German) ____
Primary Language (i.e. English/Spanish/German) ___________________________________
Primary Care Physician ________________________ Phone number _____________________
Referring Physician/Cardiologist __________________ Phone number _____________________
Reason for visit ____

Medications

Local Pharmacy Name ______________________________ Phone number ________________
Address: ____
Mail Order Pharmacy Name __________________________ Phone number ________________

Please list the medications you are currently taking

Medication	Dosage	How often per day?

List any allergies (medication, food, latex, inhalants or chemicals)

Allergy	Reaction

Surgeries and Procedures

Please list any previous surgeries and procedures:

Surgery _____________________________ Surgery ______________________________
Facility _____________________________ Facility ______________________________
Date _______________________________ Date ________________________________

Surgery _____________________________ Surgery ______________________________
Facility _____________________________ Facility ______________________________
Date _______________________________ Date________________________________

____
Name **Date**

Personal History and Risk Factors

Have you been diagnosed with any of the following?

Diabetes	Yes	No	When: _____________
Hypertension (high blood pressure)	Yes	No	When: _____________
Age>65?	Yes	No	
Dyslipidemia (abnormal cholesterol)	Yes	No	When: _____________

What type? Cholesterol Triglycerides Cholesterol & Triglycerides Low HDL Syndrome

Peripheral Vascular Disease	Yes	No	When: _____________

Family history of premature coronary artery disease (Male or Female family members under 55yrs of age)

	Yes	No	Who: ______________
Have you been hospitalized for CHF	Yes	No	When: ______________
History of prior Stroke	Yes	No	When: ______________

Please list any pertinent Family History

Adopted Yes No

Father-

Diseases ___________________________________ Age ______________ Deceased _______________

Mother-

Diseases ___________________________________ Age ______________ Deceased _______________

Brother/Sister-

Diseases ___________________________________ Age ______________ Deceased _______________

Child-

Diseases ___________________________________ Age ______________ Deceased _______________

Social History

Tobacco Usage

Current __________________

Have you ever tried to quit? _____________

Former __________________

Year quit _______________

Never ___________________

Type of Tobacco Use

Chewing _______ Units/Day _________

Cigarettes ______ Years used ________

Pipe ___________

Passive smoke exposure? ___________

Alcohol

Current ______________________

Former ______________________

Never _______________________

Type of Alcohol Use

Daily ___________________________

Frequently _______________________

Occasionally/Social ________________

Caffeine

Yes No

Type of Caffeine use (Please circle) Chocolate Coffee Tea Soda Tablets Energy Drinks

____

Name **Date**

Social History Continued

Recreational Drug Use

Current ____________________   Type of recreational drug use ______________

Former ____________________   Frequency ________________________

Year quit _____________

Never ______________________

Activity

(Please circle) Moderate   Sedentary   Unable to exercise   Vigorous

Review of Symptoms

Are you **currently experiencing** any of the following symptoms (Please check all that apply)

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cardiac:			**Respiratory:**			**Reproductive:**		
Chest Pains			**Snoring**			**History of oral contraception** (Birth Control Pills)		
Palpitations			**Hemoptysis** (Coughing up blood)			**Hematologic:**		
Diaphoresis (excessive sweating)			**Dyspnea** (Shortness of breath)			**Acute Anemia**		
Syncope			**Gastrointestinal:**			**Thrombocytopenia** (low blood platelet count)		
Orthopnea (Difficulty breathing while laying down)			**Nausea**			**Endocrine:**		
PND (Breathing disorder related to CHF)			**Reflux**			**Goiter** (enlarged thyroid)		
Vascular:			**Bleeding**			**Tremors**		
Claudication (Pain or limping in legs)			**Genitourinary:**			**Derm:**		
Edema or Swelling			**Hematuria** (Blood in urine)			**Rash**		
Constitutional:			**Frequent Urination at night** (>2 times/night)			**Skin Sores**		
Weight Gain			**Neurological:**			**Musculoskeletal:**		
Weight Loss			**Dizziness**			**Joint Pain**		
Fever			**Memory Loss**			**Myalgia (Muscle pain)**		
HEENT: (Head, Ears, Nose & Throat)			**Seizures**					
Visual Changes			**Psychiatric:**					
Hearing Loss			**Depression**					
			Hallucinations					

____

Name   **Date**