ARIZONA ARRHYTHMIA CONSULTANTS

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

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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: _____

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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

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Patient Name: _____

Date: _____

Health History Update

Please check YES or NO if any symptoms are *currently present*

NOTE: Please do not leave any blanks

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