Cardiovascular Institute OF THE SOUTH

All Subsidiaries and Physicians

PATIENT INFORMATION

If MINOR, 17 years old or younger, please fill out the Guarantor Information below.

Last Name | First Name | Middle Initial | Suffix

❑ I decline to answer the questions listed below that are requested by the U.S. Government.

Date of Birth

Social Security Number

Name of Spouse

Sex:
- ❑ Female
- ❑ Male

Preferred Language:
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Other ____________

Status:
- ❑ Divorced
- ❑ Legally Seperated
- ❑ Married
- ❑ Single
- ❑ Widowed
- ❑ Unknown

Ethnicity:
- ❑ Hispanic
- ❑ Non Hispanic
- ❑ Type-Unknown

Race:
- ❑ American Indian
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian
- ❑ White
- ❑ Type-Unknown

Physical Address: Street | City | State | Zip Code

Mailing Address: | City | State | Zip Code

Home Telephone Number | Cell Phone Number | Alternate Phone Number | Email Address

Employer | Occupation | Work Phone Number

Emergency Contact Name | Emergency Contact Phone Number | Relationship to Patient

*****Is this visit related to a Worker's Compensation Claim?** ❑ Yes ❑ No

Guarantor Information (Person Legally Responsible for minor's finances.)

Last Name | First Name | Middle Initial | Suffix

Patient's Relationship to Guarantor: ❑ Son ❑ Daughter ❑ Grandson ❑ Granddaughter ❑ Other: ____________

Mailing address | City | State | Zip Code

Sex: ❑ Male ❑ Female

Guarantor Date of Birth | Social Security Number

Status: ❑ Divorced ❑ Married ❑ Single

Home Phone Number | Cell Phone Number | Employer Name and Phone Number

Please indicate how you heard about us.

- ❑ Hospital Follow-up
- ❑ Health Fair/Screening
- ❑ Newspaper
- ❑ Television
- ❑ Radio
- ❑ Yellow Pages
- ❑ Other Patient
- ❑ Internet
- ❑ Physician
- ❑ Other:____________

Did a physician refer you to our clinic? ❑ No ❑ Yes Name: ____________

Name of your family physician: ____________

Name and Address of Referring Physician

INSURANCE INFORMATION

Please print clearly.

Primary Insurance (1)

Insurance Company Name

Policy #

If your Insurance Company is _not_ a Medicare or Medicaid plan, AND the Policy Owner (the person who owns the insurance) is not the patient, the information below must be completed for filing of medical claims.

*Policy Owner Name (person who owns insurance)

*Policy Owner Date of Birth

*Policy Owner Relationship to Patient

*Policy Owner SS#

Secondary Insurance (2)

Insurance Company Name

Policy #

If your Insurance Company is _not_ a Medicare or Medicaid plan, AND the Policy Owner (the person who owns the insurance) is not the patient, the information below must be completed for filing of medical claims.

*Policy Owner Name (person who owns the insurance)

*Policy Owner Date of Birth

*Policy Owner Relationship to Patient

*Policy Owner SS#

Tertiary Insurance (3)

Insurance Company Name

Policy #

If your Insurance Company is _not_ a Medicare or Medicaid plan, AND the Policy Owner (the person who owns the insurance) is not the patient, the information below must be completed for filing of medical claims.

*Policy Owner Name (person who owns insurance)

*Policy Owner Date of Birth

*Policy Owner Relationship to Patient

*Policy Owner SS#

BILLING POLICIES

I understand that I am responsible for the payment of this account. I agree to present my current insurance card(s) or Worker's Compensation coverage information at each visit to Cardiovascular Institute of the South (CIS) in order for verification of my healthcare benefits and accurate filing of my medical claims. I authorize my current and future insurance plan(s) or worker's compensation carrier(s) to pay my medical benefits to CIS.

I also agree to the following:

- To Pay all deductibles and co-payments at the time of service.
- To pay all allowable amounts not paid by my insurance plan(s) or other designated agency(s) within 30 days receipt of a statement.
- If there are no medical benefits or other such coverage for the charges of this account, to pay the full balance of all charges at the time of service.
- To allow CIS to verify my Worker's Compensation coverage, if applicable, with my employer or employer's insurance carrier.
- If this account becomes delinquent, to pay all collection and court fees incurred with the collection of this account.
- To allow CIS to furnish my medical information and/or copies of my medical records to my insurance plan(s) or Worker's Compensation carrier as reasonably requested for the processing of my medical claim(s).

Furthermore, I agree to notify CIS immediately if I have knowledge that my medical claims are being filed to an incorrect insurance plan(s) or Worker's Compensation carrier.

PATIENT PERSONAL HISTORY

Briefly state the reason for this doctor visit: ______________________

Please list all Medication allergies: ______________________

Please list all Non-Medication Allergies: ______________________

Are you allergic to Iodine or IVP Dye: ☐ Yes ☐ No (If Yes, List Reaction:) ______________

PAST MEDICAL HISTORY -- if your past medical includes any of the following, please check.

- ☐ Rheumatic
- ☐ High blood pressure or hypertension
- ☐ Stroke or Paralysis
- ☐ Kidney or Bladder Infection
- ☐ Tuberculosis or positive skin test
- ☐ Epilepsy
- ☐ Cancer -- treated with ☐ radiation ☐ chemo
- ☐ Bleeding tendency or blood disease
- ☐ Heart disease
- ☐ Arthritis, joint problems, or gout
- ☐ Lung or breathing problems
- ☐ Liver disease, Jaundice or Hepatitis
- ☐ Gallbladder Disease
- ☐ Thyroid Trouble

If you have, or have had, any illness or disease not included above, please list here.

REVIEW OF SYSTEMS: Please place a check mark before each of the following that apply to you.

- ☐ abnormal shortness breath with exercise or activity; spells of uncomfortable breathing or asthma
- ☐ 5 or more pounds lost or gained in past 6 months
- ☐ fluid retention and/or ankle swelling
- ☐ sleep propped up in bed
- ☐ light-headedness, dizziness, vertigo, fainting spells
- ☐ palpitations (thumping or racing heart)
- ☐ heartburn, indigestion, gas, bloating, nausea or vomiting
- ☐ periods of depression and/or anxiety
- ☐ dental problems
- ☐ problems with sexual function
- ☐ chest pain
- ☐ abdominal or back pain
- ☐ unusual fatigue and/or lack of energy
- ☐ frequent pain in legs with ☐ rest ☐ walking
- ☐ coughing up blood or mucus
- ☐ insomnia or trouble sleeping
- ☐ nosebleeds or other bleeding problems
- ☐ excessive or unexplained thirst

Indicate any symptoms you may be experiencing that are not listed above.

Please list all physicians you are currently seeing: ____________ ____________

____________ ____________ ____________ ____________

To the best of my knowledge, the information contained above is accurate and complete.

Acknowledgement of Receipt of Notice of Privacy Practices

A copy of Cardiovascular Institute of the South's Notice of Privacy Practices has been made available to me. This notice states in detail how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I should read it carefully and I am aware that the Notice may be changed at any time. I may obtain a revised copy of the CIS Notice by requesting one at any CIS office or by visiting the web site at www.cardio.com.

E-Prescribing Information and Patient Consent

What is E-prescribing and Why Does CIS E-Prescribe?

E-Prescriptions, or Electronic Prescriptions, are computer generated prescriptions created by your provider and sent directly to your pharmacy. CIS participates in E-Prescribing because we care care about your health and wellbeing and E-prescribing has multiple safety benefits.

How does E-Prescribing Work?

Instead of writing out your prescriptions on a piece of paper, your doctor enters it directly into the computer. Your prescription travels from your doctor's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open internet or as email. Your e-prescription arrives at the pharmacist's computer faster and may help to save you time. The e-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept e-prescriptions, you provider can print your prescriptions for you.

Privacy

The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPPA). HIPPA requires that your personal health information be shared only for the purpose of providing you with clinical care. E-prescriptions meet this requirement.

Patient Consent for E-Prescribing

I, agree that Cardiovascular Institute of the South may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefits payors for treatment purposes.

PATIENT CARE STATEMENT

It is the policy of the Cardiovascular Institute of the South (CIS) and its physicians to inform each patient that we strive to deliver excellence in health care. However, we feel that it is critical that our patients fully understand that cardiovascular disorders are by their very nature serious and capable of causing immediate death or disability. It is important that expectations are not unrealistically high.

There are no isolated tests or laboratory findings that absolutely pinpoint diagnoses. In fact, the patient's symptoms are often the most reliable predictors of problems. At other times, however, major problems may show no symptoms at all. The treatment and diagnostic tests employed in treating patients with cardiovascular disorders vary from institution to institution, as well as amongst individual physicians at the same institution. Physicians base their approach on prior training, results of prior treatments, and philosophies of medical care. Medical science and literature abound with different opinions about how best to diagnose, treat, and follow patients with cardiovascular disorders. It is expected that different physicians may have different opinions and methods, all of which may be reasonable.

BECAUSE OF THIS, WE ENCOURAGE OUR PATIENTS TO ASK ANY QUESTIONS WHEN THEY ARE UNSURE. WE ENCOURAGE SECOND OPINIONS FROM ANY PHYSICIAN THAT THE PATIENT CHOOSES.

As cardiovascular disorders often involve multiple organ systems such as the brain, heart, intestines, kidneys, and legs, it is often important to evaluate other crucial organs before proceeding with treatment. In fact, sometimes patients have to be treated for more life-threatening conditions before we can address the problems that cause their presenting symptoms. In particular, some success in the non-surgical treatment of vascular blockages of the legs has led us to take a more aggressive approach than some centers. While this approach has resulted in limb salvage and alleviation of leg pain in numerous patients while sparing veins for future use and avoiding surgery, there are significant risks, including but not limited to death, brain damage, paralysis of both legs and both arms, loss of an internal or external organ, loss of an arm or leg, loss of function of an internal or external organ, loss of function of an arm or leg, disfiguring scars, bleeding (both internal and external), reaction or allergy to dye, stroke, heart attack, kidney failure, and infection. Many patients with leg blockages have diabetes, kidney disorders, blocked heart arteries, and/or blocked arteries to the brain that must be treated first and these conditions increase the chances of the complications mentioned immediately above.

Patients at CIS can expect to see several different doctors. This is to allow for prompt and efficient healthcare that would not be possible from one physician. No one physician can be awake, alert, and efficient twenty-four hours a day. The patient also benefits from the opinions of multiple physicians.

CIS, its subsidiaries, and their physicians are sometimes involved in experimental or investigational therapies. Those therapies are limited to those we feel offer our patients greater benefits than existing, established therapies. By the very nature of the word "experimental" it must be understood that the short and long term results of these measures have not been clearly determined.

In striving to offer our patients the latest in medical and surgical therapy of their disorders, we sometimes use newly released medications that may ultimately be found to have adverse or unexpected effects. In fact, complications can and do occur with all medical and surgical treatments, even with the best of care.

As medicine is not an exact science and conditions do change, ideal medicine requires communication, cooperation, mutual respect, and appropriate follow-up. We have patient representatives whom we encourage our patients to notify if there are any questions, concerns or miscommunications.

Continued

PATIENT CARE STATEMENT cont.

Although we strive for excellent results, it must be understood that there are conditions beyond our control and that patients with cardiovascular disorders are some of the highest risk patients. Patients with these problems can and do have complications and some even die. **In fact, cardiovascular disorders are the leading cause of death and disability in America.**

WE STRIVE TO DELIVER THE SAME KIND OF CARE THAT WE WOULD WANT FOR OUR OWN FAMILIES. THIS, UNFORTUNATELY, DOES NOT GUARANTEE SUCCESS, AND WE THEREFORE CANNOT AND DO NOT GUARANTEE RESULTS OR SUCCESS.

PATIENT CARE CONTRACT

I understand that I am in large measure responsible for my health.

I understand that I must communicate any problem that I have to my physician, and that I must follow recommendations made by that physician. Unhealthy practices such as smoking, leaving the hospital against medical advice, failure to take medications, failure to appropriately exercise, and failure to follow the physicians' advice may be very harmful to my health.

I understand that medical science is not perfect and that physicians cannot detect all problems by physical examination and laboratory results. It is my responsibility to communicate to the physicians, or their staff, all symptoms or changes in symptoms. Even in the best of circumstances, medical treatment is not always successful.

I understand that optimal results require routine follow-up.

I understand that this contract is meant to advise me of the importance of communication and follow-up and to make me aware of the limitations of medical success so that I will not have unrealistically high expectations of improvement or success.

I understand that I must accept responsibility for my care and I absolve Cardiovascular Institute of the South, its subsidiaries, physicians and staff from any problems that may arise because of my failure to follow medical advice at any time during my treatment. I also clearly recognize that no improvement, cure or success is guaranteed—and possibly none will result.

In signing this document, I acknowledge that I have provided the most accurate and complete information to the best of my knowledge; I have read and understand the policies and statements; I will request further information as necessary concerning:

- **Patient Information (pg 1 of 7);**
- **Insurance Information (pg 2 of 7);**
- **Billing Policy (pg 3 of 7)**
- **Patient Personal History (pg 4 of 7);**
- **Acknowledgement of Receipt of Notice of Privacy Practices (pg 5 of 7);**
- **E-Prescribing Consent (pg 5 of 7);**
- **Patient Care Statement (pg 6/7 of 7);**

Patient's Name	Patient's Signature	Date

As a representative of the about individual, I acknowledge the above on their behalf.

Patient's Representative	Representative's Signature	Relationship to Patient	Date