TRI-CITY CARDIOLOGY CONSULTANTS, P.C.

Welcome Letter

Dear Patient,

Thank you for choosing Tri-City Cardiology for your care. Our goal is to provide you with very good care and service. The following information is provided to help you have a very good experience at our clinic:

- **New Patient Packet**: All new patients need to complete these forms and bring them to their visit:
  - Patient Information
  - Financial Policy
  - Authorization to release Personal Health Information (PHI)
  - Sleep Evaluation
  - Peripheral Vascular Disease (PVD) Screening

- **Items To Bring to Your Appointment**:
  - Current medication list including vitamins, supplements, and over the counter medications.
  - Current insurance cards
  - Credit Card, Checkbook, or cash for payments owed at the time of service.

- **Arrival Time**: It is **very important** that you arrive **20 minutes prior to your appointment time** to begin your registration process which includes updating your demographic, insurance and health information. Please allow enough time to park, if your appointment is at the Banner Heart Hospital Campus.

- **Late Arrival Policy**: If you arrive more than fifteen (15) minutes late, you may be asked to reschedule your appointment(s).

- **Testing appointments** run on time. If you are late for your testing appointment, you may or may not be allowed to test, depending on the testing schedule. If you are unable to test because you are late or miss your appointment, there will be a $25.00 charge added to your account.

- **All Appointments:** Failure to cancel any appointments within 24 hours (1 full business day, Mon – Fri) of your appointment will result in a $25.00 charge added to your account.

- **Co-Pay, Co-Insurance, and Account Balance Payments**: Please be prepared to pay your co-payments, deductibles, and any outstanding balances due at the time of your visit. Please refer to the Financial Policy for your financial obligations as a patient.

- **Patient Rooming**: The rooming process begins when the medical assistant escorts you from the waiting room to an exam room to obtain updated health information, vital signs, etc to prepare for your visit with the physician.

- **Appointment Time**: Your appointment time is the time you are to begin your exam or procedure. Your physician will be using a computer in the exam room to access and update your medical information as part of an electronic medical record process.

- **Checkout Process:** The Discharge Scheduler will schedule any testing or follow up visits ordered by the physician. You will be provided a Clinical Summary of your visit at that time.

- **Communicating with our practice:** Following your visit, there are several methods to reach our staff:

  - **Patient Portal** – **www.nextmd.com**
    - This is a secure website for patients to communicate with our practice, request appointments and medical records, receive statements and pay account balances, etc.
    - **This is our preferred method of communication with patients so please register for the Patient Portal as soon as possible.** Ask any staff member on how you can enroll in the Patient Portal.
  - **Telephone** – to minimize your wait time on the phone, please follow these instructions
    - Our high volume call times are Monday all day and from 8:30-10:00 and 1:00 – 2:30 pm daily.
    - Use the call back feature offered after one minute of hold time. Follow the instruction prompts for using this feature.
    - The following selections will be offered when you call in to expedite your call:
      - Option 2 for Scheduling
      - Option 3 for your physicians secretary
      - Option 4 for other services, then press:
        - Option 1 for Office hours, locations, and fax numbers
        - Option 2 for Medical Records
        - Option 3 for Billing
        - Option 4 for prescription questions
        - Option 5 to leave a non-urgent voice message
        - Option 6 returns you to the main menu above
        - Option 7 replays "Other" options
  - **Website** – **www.tricitycardiology.com**
    - Visit our website to see information about our physicians and our practice but use the **Patient Portal** for **SECURE** communication with our practice.

- **Patient Satisfaction:** Your satisfaction is very important to us! You will be receiving a confidential, electronic survey via e-mail from Press Ganey so be sure to provide your email address to our Scheduling or Registration Staff. Your honest feedback is appreciated so we can continue to improve our services!

  Again, thank you for choosing Tri-City Cardiology for your medical care!

  The Physicians and Staff of Tri-City Cardiology

Tri-City Cardiology Consultants, PC
Phone: 480-835-6100 Fax: 480-461-4243
www.tricitycardiology.com
Patient Portal: www.nextmd.com

PATIENT INFORMATION FORM
Tri-City Cardiology Consultants, P.C.

Dobson ☐ Baywood ☐ Gilbert ☐ Ironwood ☐ Vein Center ☐

Patient Name: _____ Date of Visit:_____
First Last M.I.

Date of Birth: _____ Age:_____ Sex:_____ Height:_____ Weight:_____lbs.

Referring Doctor:_____ Primary Care Doctor:_____

Reason for Visit (current symptoms today):_____

Recent hospitalization? If yes, please explain:_____

Drug/Food Allergies

Are you allergic to any medications: ☐ Yes ☐ No

Medications you are allergic to: Reaction:

_____ _____

_____ _____

_____ _____

Other allergies (food, adhesive tape, iodine, latex, etc.): _____

Current Medications (please list all prescription, non-prescription, vitamins and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	DOSAGE (How many & times per day)	DO YOU NEED ANY REFILLS?
Example: Lopressor	*50 mg*	*1 tablet, two times a day*	30 Days or 90 Days
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90
			☐ Yes ☐ 30 ☐ 90

Local Pharmacy (name & crossroads):_____ Phone: ( )_____-_____

Mail Order Pharmacy:_____ Fax: ( )_____-_____

Risk Factors

Do You Use Tobacco: ☐ Current ☐ Former ☐ Never **If former, Year Quit:**_____

If Yes, Type: ☐ Chewing ☐ Cigarettes ☐ Pipe ☐ Smokeless

Packs/day_____ Years used_____ Passive smoke exposure: ☐ No ☐ Yes

Have you ever been diagnosed or are taking medications for the following conditions:

Diabetes: ☐ Yes ☐ No ☐ Unknown **If Yes, Type:** ☐ Type 1 (Juvenile) ☐ Type 2 (Adult onset) **Year diagnosed**_____

High Cholesterol: ☐ Yes ☐ No ☐ Unknown

If Yes, Type: ☐ Cholesterol ☐ Triglycerides ☐ Cholesterol+Triglycerides ☐ Low HDL Syndrome

High Blood Pressure: ☐ Yes ☐ No ☐ Unknown **Year diagnosed**_____

Family History of Heart Disease(CAD) prior to age 55: ☐ Yes ☐ No ☐ Unknown ☐ Adopted (No Fam Hx Unknown)

Peripheral Vascular Disease (poor circulation in legs): ☐ Yes ☐ No ☐ Unknown

Social History

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed ☐ Life Partner ☐ Other:_____

Do you have children: ☐ No ☐ Yes **If Yes**, Number of sons:_____ Number of daughters:_____

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian
☐ Pacific Islander/Native Hawaiian Other ☐ _____ ☐ Declined

Do you follow a specific Diet: *(check all that apply)*

☐ Diabetic ☐ Low Carb ☐ Low Fat, Low Chol ☐ Low Salt ☐ No Added Salt ☐ No specific diet
☐ Regular ☐ Renal ☐ Vegetarian ☐ Weight loss ☐ Other:_____

Activity Level (exercise): ☐ Sedentary ☐ Occasional ☐ Regular ☐ Active Life Style ☐ Physically Unable to Exercise

Exercise Type: *(check all that apply)* **Frequency:**_____*(times per week)*

☐ Aerobics ☐ Cycling ☐ Dancing ☐ Elliptical ☐ Jogging ☐ Physical Therapy ☐ Running ☐ Swimming
☐ Team Sports ☐ Walking ☐ Weight lifting ☐ Other:_____

Do you consume Alcohol: ☐ Yes ☐ No ☐ Former **If Yes, What Type:** ☐ Beer ☐ Wine ☐ Liquor
If Yes, Frequency: ☐ Rarely ☐ Frequently ☐ Social ☐ Occasional ☐ Daily **Drinks per week:**_____

Do you consume Caffeine on a daily basis: ☐ Yes ☐ No **Cups per day:**_____
If Yes, What type: ☐ Chocolate ☐ Coffee ☐ Energy Drink ☐ Soda ☐ Tablets ☐ Tea ☐ Other:_____

Drug use/Abuse: ☐ Yes ☐ No ☐ Former **If Yes, What type:**_____

Advanced Directives: ☐ None ☐ DNR ☐ HC Proxy ☐ Living Will

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

Family History

☐ Unknown- *(Unknown)Family Hx*
☐ Adopted - *(Unknown)Family Hx*

Place a check mark in the box for any conditions below that apply:

RELATIONSHIP TO PATIENT:	MOTHER	FATHER	SISTER	SISTER	BROTHER	BROTHER	OTHER: _____
CURRENT AGE:							
AGE AT DEATH:							
HEART ATTACK:							
ARRHYTHMIA:							
HEART FAILURE:							
ANEURYSM:							
STROKE(CVA):							
HIGH BLOOD PRESSURE:							
HIGH CHOLESTEROL:							
DIABETES:							
LUNG DISEASE:							
RENAL DISEASE:							
CANCER: Type:_____							

Other pertinent family history: _____

Past Medical History
Place a check mark in the box for any of the conditions that apply:
Respiratory: ☐ COPD ☐ Pulmonary Embolus ☐ Pulmonary Hypertension ☐ Sleep Apnea ☐ Other:_____
Renal: ☐ End Stage Renal Disease ☐ Renal Artery Stenosis ☐ Renal Insufficiency ☐ Other:_____
Endocrine: ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Obesity ☐ Other:_____
Oncology: ☐ Breast Cancer ☐ Skin Cancer ☐ Lung Cancer ☐ Prostate Cancer ☐ Other:_____
☐ Chemotherapy ☐ Radiation ☐ Other:_____
Cardiac: ☐ Arrhythmias ☐ Congestive Heart Failure ☐ CAD ☐ Heart Attack (MI) ☐ Valvular Heart Disease
☐ CABG (Bypass) ☐ Coronary Stent ☐ ICD ☐ Pacemaker ☐ PTCA (Angioplasty) ☐ Other:_____
Vascular: ☐ Abdominal Aneurysm ☐ Peripheral Arterial Disease ☐ Carotid Disease ☐ DVT ☐ Thoracic Aneurysm
☐ Varicose Veins ☐ Amputation ☐ Aneurysm Repair ☐ Vein Stripping ☐ Other:_____

List any other medical conditions: _____

_____

_____

List any other surgeries: _____

_____

_____

Cardiac Testing	Yes	No	Date or Year	Location or Hospital	Additional Comments
Echo (ultrasound):	☐	☐			
Electrophysiology:	☐	☐			
Cath Lab:	☐	☐			
Vascular:	☐	☐			
Stress Test:	☐	☐			
CT/MRI:	☐	☐			
Other: _____	☐	☐			

Any other cardiac testing: _____

_____

_____

Review of Symptoms					
Check only the problems you are currently experiencing:					
	Y	**N**		**Y**	**N**
Cardiac:	○	○	Chest Pain (pressure)	○	○ Diaphoresis (excessive perspiration)
	○	○	Palpitation (fluttering)	○	○ Syncope (loss of conciousness)
	○	○	Orthopnea (trouble breathing lying down)	○	○ PND (trouble breathing at night)
Vascular:	○	○	Claudication (leg pain w/walking)	○	○ Edema (swelling)
Constitutional:	○	○	Weight Gain	○	○ Weight Loss
	○	○	Fever		
HEENT:	○	○	Visual Changes	○	○ Hearing Loss
Respiratory:	○	○	Snoring	○	○ Cough
	○	○	Dyspnea (shortness of breath)	○	○ Hemoptysis (coughing up blood)
				○	○ Wheezing
Gastrointestinal:	○	○	Nausea	○	○ Reflux
	○	○	Bleeding	○	○ Constipation
				○	○ Diarrhea
Genitourinary:	○	○	Hematuria (blood in urine)	○	○ Nocturia (nighttime urination)
Neurology:	○	○	Dizziness	○	○ Memory Loss
	○	○	Seizures		
Psychiatric:	○	○	Depression	○	○ Hallucinations
Hematologic:	○	○	Acute Anemia	○	○ Thrombocytopenia (low platelet count)
Endocrine:	○	○	Goiter (enlarged thyroid)	○	○ Tremors
Derm(Skin):	○	○	Rash	○	○ Skin Sores
Musculoskeletal:	○	○	Joint Pain	○	○ Myalgia (muscle pain)

Any additional symptoms you are experiencing: _____

_____

_____

Patient Name (printed): _____ **Date:** _____

TRI-CITY CARDIOLOGY CONSULTANTS, P.C.

Financial Policy

Dear Patient,

Our goal is to provide you with very good care and service. Attached is a copy of our financial policy. It is very important you review this policy. If you have any questions before your appointment please call (480) 844-0401 to speak with a financial counselor.

Each visit, during the registration process, your statement or account balance will be reviewed with you by a financial counselor or registrar prior to services rendered. The final part of your registration process will be to review your financial obligations to ensure the accuracy of your bill. We will ask you to pay any co-payments, deductibles, and outstanding balances at this time.

In addition, your registration process will include updating your demographic, insurance, and health information. This process will improve the quality of patient information we use to care for you.

Being true to our Mission Statement we will work collaboratively with patients who are under financial hardship to develop fair and reasonable payment plans. Financial hardship is determined by policy and is a formal process that must be a joint effort between a financial counselor and the patient. A patient, who has the ability to pay and has not been formally determined to be in financial hardship, is expected to pay at the time of service and maintain no outstanding balance.

Our policy states that any account balance remaining after insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time. All co-pays, deductibles, and previous account balances must be paid before additional services will be rendered.

We hope this brief overview is helpful. We are excited about the opportunity to provide you with very good care and service. If you have any questions or concerns, please contact Billing at 480-844-0401. Thank you.

Billing Questions
6402 E. Superstition Springs Blvd, Suite 224
Mesa, AZ 85206
(480) 844-0401

Rev 12.13

TRI-CITY CARDIOLOGY CONSULTANTS, P. C.
FINANCIAL POLICY

Patient Responsibilities

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Tri-City Cardiology (TCC) of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments **directly** to TCC. Any payments sent directly to the patient should be forwarded to TCC with the Explanation of Benefits to prevent your account being subject to collection procedure and legal action. Authorization must be signed at the initial visit, upon any change in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage.
These services will help you to verify that TCC is a participating provider with your insurance company. All referrals to TCC are to be obtained **prior** to your appointment. This will prevent your appointment from needing to be rescheduled.

Payment Policy

Insured

All co-pays and deductibles must be paid before services are rendered. If unable to pay your copay at the time of service, your appointment may be rescheduled. Non-contracted insurance claims will be submitted to the insurance company as a courtesy to you however the charges remain your responsibility. If no response is received from your insurance within 60 days, payment must be made by you.

Non-Insured

TCC requires full payment at the time of service unless prior arrangements have been made with our Billing Office.

Balances Due

Patient balances remaining after insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

Medical Forms

TCC requires full payment of $50.00 at the time your Insurance forms (FMLA, FAA Clearance, Disability, etc.) are dropped off for completion. Completion of forms is not paid by your insurance company.

24 hour Cancellation for Appointments

TCC requires a 24 hour advance notice for all appointment cancellations. 24 hour advanced notice is defined as 1 full *business* day, Monday through Friday. Failure to cancel your appointment within these hours will result in a $25.00 charge added to your account. This charge is not covered by your insurance and is the patient's responsibility.

Hospitalizations

It is your responsibility to notify your insurance company and primary care physician's office in the event of an unscheduled hospitalization. It is also your responsibility, not the hospital's to provide TCC with your insurance information.

Non-Sufficient Funds/Return Checks

TCC will pass along to the patient a $40.00 NSF bank charge for all returned checks. This fee will be added to your account and is the patient's responsibility. The financial institution may charge additional fees to you directly.

_____

Print Name Date of Birth

_____

Signature Today's Date

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI)
Tri-City Cardiology Consultants, P.C.

Patient Name _____ Date of Birth_____

1) Please check (√) one only:

¤ I only want my medical information released to myself.

¤ I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care. This authority will be in effect for one (1) year.

RELATIONSHIP TO PATIENT

_____

_____

2) Emergency Contact Name _____

Emergency Contact Phone Number _____

3) Please Initial below:

_____ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers _____, _____

_____ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature _____ Date _____

Witness _____

ABOVE INFORMATION REMAINS UNCHANGED		
Signed by:	Date:	Witness:
Signed by:	Date:	Witness:

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORIZATION TO RELEASE PHI** but could not because:

□ Individual refused to sign □ Communication barrier □ Care provided was emergent □ Other

_____

Employee Name _____ Date _____

SLEEP EVALUATION
Tri-City Cardiology Consultants, P.C.

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

Trouble sleeping can impact your heart and your blood pressure. In an effort to promote cardiovascular health, we are committed to identifying patients with sleep disorders.

Please take a moment to place an "X" in the appropriate column next to each statement below. If you have marked "yes" next to two or more of these statements, further evaluation of your sleep patterns may be warranted. Your physician will be happy to further discuss this with you during your appointment.

	Yes	No
1. I snore often or disturb others with my snoring.		
2. I have been told of pauses or stopping breathing during sleep.		
3. I have difficulty waking up or I am sleepy during the day.		
4. I am tired during the day, take naps or fall asleep during activities like reading, working on a computer, or watching TV.		
5. I have headaches when I wake (more than 2 times per week).		
6. I often wake more than 3 times a night.		
7. I often wake to use the bathroom more than twice a night.		
8. I am being treated for at least one of the following conditions: high blood pressure, heart failure, or atrial fibrillation.		
9. I am prescribed to take 3 or more medicines for blood pressure.		
10. I am being followed for diabetes or pre-diabetes.		

PERIPHERAL VASCULAR DISEASE (PVD) SCREENING
Tri-City Cardiology Consultants, P.C.

Patient Name:_____ Date: _____ Date of Birth: _____

Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PVD.

Please circle "Yes" or "No" on the following questions and check all boxes that apply:

1. Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? Yes No

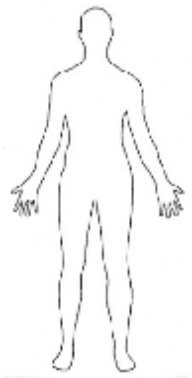
2. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms? Yes No
   If yes, dates: _____

3. When you walk, do you experience aching, Cramping, or pain in your arms, legs, thighs, or buttocks? Yes No

4. If you answered Yes to #3, when do you feel the pain:

   - ¤ After walking 1 block
   - ¤ Climbing a flight of stairs
   - ¤ After walking 100 yards
   - ¤ Walking at increased speed

5. If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.



6. If you have pain, does the pain subside with rest? Yes No

7. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? Yes No

8. Do you have any painful sores or ulcers on legs or feet that do not heal? Yes No

9. Are your legs or arms pale, discolored, or bluish? Yes No

10. Check all that apply:

    - ¤ I am a current smoker
    - ¤ I have a history of smoking
    - ¤ I have diabetes
    - ¤ I have a family history of diabetes
    - ¤ I have high cholesterol
    - ¤ I have a family history of high cholesterol
    - ¤ I have high blood pressure/hypertension
    - ¤ I have a family history of high blood pressure/hypertension
    - ¤ I have coronary artery disease (CAD)
    - ¤ I have a family history of coronary artery disease
    - ¤ I have had a stroke/mini-stroke/TIA
    - ¤ I have a family history of stroke/mini-stroke/TIA

TRI-CITY CARDIOLOGY CONSULTANTS, P.C.

MEDICATION MANAGEMENT

Dear Patient,
Proper management of your medications is very important to your care plan. It is important that we work together to educate you on your medications and that we maintain an accurate medication list.

- **Please bring your current medication lists, <u>including dosage and instructions to every office visit with your physician.</u>**
  - Be prepared to provide information about **<u>new</u>** medications since your last office visit.
- **If you have been discharged from the hospital in the last sixty (60) days, it is important to bring your hospital discharge instructions that contain your most recent medication instructions.**

<u>Managing Prescriptions Refills</u>
Tri-City Cardiology is compliant with Electronic Prescription requirements, therefore:

- **<u>All refill requests for medication must be made through your local or mail order pharmacy.</u>**
- If you need a refill authorization (if you are out of refills), you must call your Pharmacy. The pharmacist is in the best position to safely and accurately coordinate the request with our staff.
- Request your refills <u>at least 7 days BEFORE</u> you will run out of medication to allow time for processing of your refill.
- If your prescription has expired, <u>allow at least two weeks</u> for your pharmacy to process the new prescription.
- If your prescription medication requires authorization from your insurance or you use a mail order pharmacy, allow <u>at least 30 days</u> for this process to be completed.

<u>Understanding Your Medications</u>
It is important that you know what medication(s) you are taking and how to take them. Be prepared for your visit by asking questions about your medications of your other physician(s) who prescribed them or pharmacist.

- Know the name and dosage of the medication(s). Keep a list with you.
- Know when you should take your medications and what to do if you miss a dose.
- Know the side effects (for example, drowsiness or nausea).
- Know if your medication(s) could interact with any over the counter non-prescription medications that you may be taking or whether you should avoid alcohol while taking a medication.

Thank you for your cooperation with following the above instructions to help process all of your medication requests and questions timely and accurately! Our goal is to ensure you understand and take your medications as directed by your physician for your best health benefit.

Tri-City Cardiology Consultants, PC
Phone: 480-835-6100 Fax: 480-461-4243
<u>www.tricitycardiology.com</u>
Patient Portal: <u>www.nextmd.com</u>

TRI-CITY CARDIOLOGY CONSULTANTS, P.C.

Directions and Maps to Tri-City Cardiology Office Locations

<u>TCC Dobson – Banner Desert Campus</u>
1520 S. Dobson Rd. · Suite 209 · Mesa, AZ 85202
Main Phone: (480) 835-6100

Directions:
• Traveling from the **East or West** on Highway 60 in Mesa, take the Dobson Road exit.
• Turn North onto Dobson Road and at the first stop light intersection turn West (Left) into the Banner Desert Medical Center Campus.
• Turn left at the stop sign and follow the curved road around to the south side of the hospital.
• Take a left at the stop sign. This will put you into the under building parking garage labeled "1520 Building".
• There are two elevators, one on the Northeast side of the parking lot and one on the Southwest side of the parking lot. Take an elevator to the 2nd floor. We are located on the Southeast side of the walkway in suite 209.

<u>OR</u>

• Traveling from the **North or South** on highway 101, take the Southern Ave/Baseline Rd exit, turn east to Dobson Road, turn South and at the 2nd stop light turn west into the Banner Desert Medical Center Campus.
• Turn left at the stop sign and follow the curved road around to the south side of the hospital.
• Take a left at the stop sign. This will put you into the under building parking garage labeled "1520 Building".
• There are two elevators, one on the Northeast side of the parking lot and one on the Southwest side of the parking lot. Take an elevator to the 2nd floor. We are located on the Southeast side of the walkway in suite 209.

<u>TCC Baywood – Banner Heart Hospital Campus</u>
6750 E. Baywood Ave. · Suite 301 · Mesa, AZ 85206
Main Phone: (480) 835-6100

Directions:
• Traveling East or West on Highway 60 in East Mesa, take the Power Road exit.
• Turn North onto the Power Road exit.
• Travel through the stop lights at Southern Ave., Broadway Rd and Baywood Ave. Immediately after Baywood Ave., take the entrance into the Banner Heart Hospital.
•Travel up the ramp to the top level of the Banner Heart parking deck. Park and enter the hospital on the lobby level. There are two sets of elevators off the main lobby. Take either set of elevators to the 3rd floor.
•We are located in Suite 301.

Note: A complimentary shuttle service will be driving around the parking lot throughout the day to assist you to and from the front entrance of the Heart Hospital to your vehicle.

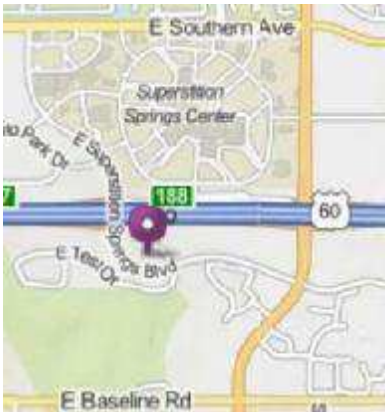
TCC Gilbert – Spectrum Falls Complex
2680 S. Val Vista Dr. · Bldg 15, Suite 185 · Gilbert, AZ 85295
Main Phone: (480) 835-6100

Directions:
• Traveling East or West on Highway 60 in East Mesa, take the S. Val Vista exit, then head South. - or – Traveling East or West on South Santan Fwy/Loop 202, take the S. Val Vista exit, then head North.
• Turn West into the Spectrum Falls Complex.
• Follow the signs to building 15, which is on the North end of the complex.
• We are located in Suite 185.

TCC Ironwood – Banner Ironwood Medical Center Campus
37100 N. Gantzel Rd. · Suite 202 · San Tan Valley, AZ 85140
Main Phone: (480) 835-6100

Directions:
• Traveling East or West on Highway 60 in East Mesa, take the Ironwood exit, # 195 and turn South onto S. Ironwood Dr.
• S. Ironwood Dr. turns into N. Gantzel Rd.
• After Combs, our office building will be on your west side.
• Take the first entrance into the Ironwood Medical Center.
• Make your first left into the parking lot of the "Medical Pavilion" .
• We are located in suite 202.

TCC Vein Center, Administration and Billing Office
6402 E. Superstition Springs Blvd. · Suite 224 · Mesa, AZ 85206
Main Phone: (480) 835-6100
Billing Phone: (480) 844-0401



Directions:
• Traveling from the **West** on Highway 60 in East Mesa, take the Superstition Springs Blvd. exit.
• Turn South onto Superstition Springs Blvd.
• Follow the curve to the left and take your first left at Test Drive.
• Take the first left into the parking lot.
• We are located in suite 224.

-OR-
• Traveling from the **East** on Highway 60 in East Mesa, take the Power Rd exit.
• Turn South onto Power Rd.
• Turn right onto Superstition Springs Blvd.
• Follow to the stop light at Test Drive and turn right.
• Take the first left into the parking lot.
• We are located in suite 224.

Tri-City Cardiology Consultants, PC
Phone: 480-835-6100Fax: 480-461-4243
www.tricitycardiology.com
Patient Portal: **www.nextmd.com**