PREMIER HEART

Patient Information:
Last Name:_____First Name:_____ MI:_____
Date of Birth:_____ Gender:_____
SSN:_____
Primary Care Provider:_____
Primary Care Provider Phone Number:_____
Local Pharmacy:
Name:_____Address:_____
City, State, Zip:_____Phone Number:_____

Marital Status:	**Preferred Language:**	**Race:**
Single Married Other	English Spanish Other	White Asian Black or African American Native American Other Decline

Patient Contact Information:
Address Line:_____ Address Line 2:_____
City:_____ State:_____ Zip_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Preferred phone: Home, Mobile, Work
Email:_____ Communication Preference:_____

Employment Information:
Employer Name:_____ Employer Phone:_____
Address Line 1:_____ Address Line 2:_____
Employer City:_____ State:_____ Zip:_____

Emergency Contact:
Contact Name:_____ Relationship to patient:_____
Address Line 1:_____ Address Line 2:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell phone:_____ Work phone:_____

Insurance Information:
Primary Insurance:_____ Secondary Insurance:_____
No insurance or Self Pay

Holder of Insurance:
Last Name:_____ First Name:_____ MI:_____
Date of Birth:_____ Social Security Number:_____
Primary Phone Number:_____ Sex:_____ Relation:_____

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED on the balances owing to the provider that are past due.

Print Patient Name:	**Date:**
Patient Signature/ Legal Representative:	
Print name of Signature if different than Patient:	

Notice to all Patients:

IF YOUR MEDICAL INSURANCE REQUIRES A REFERRAL, YOU WILL NEED TO GET IN TOUCH WITH YOUR PRIMARY CARE PROVIDER TO LET THEM KNOW WHEN YOUR SCHEDULED APPOINTMENT IS AND TO ASK THEM TO ENTER A REFERRAL FOR YOU.

All office visits, diagnotic testing, or procedures scheduled at Premier Heart and all hospital testing or procedures billed by Premier Heart are subject to the following cancellation policy as follows:

Cancellations for any of the above must be made 48 hours prior to the scheduled time.

Failure to notify the office in less than 48 hours prior to the scheduled appontment time will result in a bill sent directly to the patient for $50.00. This is not a covered medical insurance benefit and will be payable to the office directly by the patient.

I _____, have read the office cancellation policy stated above. I understand and agree to pay $50.00 for failure to contact the office 48 hours prior to my scheduled appointment per appointment scheduled at Premier Heart's Office or at the Hospital with Dr. Kernis.

Signature/ Legal Representative:_____

Date:_____

Patient Authorization and Consent

Patient Name: _____ Date of Birth: _____

I am presenting myself for treatment at Premier Heart, LLC. I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by the employees and medical staff of Premier Heart, which, in their professional judgement, is necessary or beneficial. I understand that this consent applies to this and to all subsequent visits as a patient relating to the diagnosis and treatment of my medical condition(s).

I agree that my provider can check my external medication history at his/her discretion.

I hereby authorize payment directly to Premier Heart the benefits under the insurance coverage(s) identified by me which may be payable to me but not to exceed the regular charge or all services rendered. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable or provider services or authorize such provider of submit claims to the insurer for payment.

I understand that I am financially responsible for all charges not paid under this assignment. I further understand that my provider cannot know all the terms of my insurance and that if my insurance declines payment for any reason I am responsible for payment of all declined charges. I understand and agree that in the event that I fail to make payment for service rendered to me, my identifying information will be turned over to a collection agency and/or attorney, and I will be responsible for all costs associated with collecting payment including but not limited to attorney's fees, court costs, and collection agency fees.

The undersigned agrees whether she/he signs as agent or as patient, that in consideration of the services to be rendered to the patient she/he hereby individually obligates herself/himself to promptly pay the account of Premier Heart in full upon presentation of any portion denied or not covered by the patients insurance carrier. Provisional credits are subject to collections thereof by Premier Heart.

I authorize Premier Heart along with any billing service and/or their collection agency or attorney who may work on their behalf, to contact me on my cell phone and or home phone, and/or may use pre-recorded messages, artificial voice messages, automated telephone dialing devices or other computer assisted technology, or by electronic mail, text message or by any other form of electronic communications.

I authorize Premier Heart to electronically share my medical information through Health Information Exchanges for the purpose of coordinating patient care, treatment, payment, health care operations, and other authorized purposes to the extent permitted by law. I acknowledge that I have been informed of my rights to "opt out" or decline participation in Health information exchanges.

I certify that the information given by me is correct.

I certify that I have been provided with the HIPAA guidelines for confidentiality as pertain to Premier Heart and its providers. I understand that I may receive additional copies at any time upon request. I understand that staff are available to answer any questions regarding the HIPAA guidelines.

The undersigned certifies that she/he has read and understands the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Patient/ Legal Representative Signature: _____ Date: _____

The Patient is unable to sign because: _____

Welcome to Premier Heart!

We are pleased you have chosen Premier Heart for your cardiovascular care. We appreciate your trust in us. We specialize in providing premier cardiovascular care in South Jersey and Philadelphia.

Our team of medical professionals uses a coordinated approach to care that focuses on each patient's individual needs.

Premier Heart offers appointments on the same day, when possible, most days of the week for all patients. These convenient appointments are designed to provide you with timely access to our medical care and help you to avoid potential costly and timely hospital emergency room or urgent care visits.

Premier Heart offers an electronic, web-based patient portal to communicate with your provider, office staff, request prescription refills and labs, view upcoming appointments and more. Please provide your email for this if you are interested and let the office staff know that you would like to sign up for this.

Appointment Policies:

Please arrive 15 minutes prior to your scheduled appointment time to check in. Patients who arrive more than 15 minutes after their scheduled appointment time may be asked to reschedule.

We require 48 hours' notice if you are unable to keep your appointment. This will allow us to have ample time to schedule another patient who may have an urgent need.

Medical Records:

We request that you have any recent medical records forwarded to our office prior to your first appointment. Please complete the enclosed form, "Authorization for Release of Information", and submit to your previous physician so we may review those records in collaboration with your current records.

Financials:

Copays and deductibles are due at the time of your visit. We accept cash, check or credit card.

All outstanding balances are to be paid in full at the time of your visit unless payment arrangements have been made with our billing department.

All self-pay patients are requested to pay for their visit in full at the time of service.

Failure to get necessary referrals prior to visit may result in you being responsible for the bill.

Prescription Refill Request:

Please have pharmacy request a refill electronically. You may also request through the portal or by calling the office. Please give a minimum of 72 hours' notice for a refill.

Patient Code of Conduct:

Our goal at Premier Heart is to treat every patient and their family with dignity and respect. It is our expectation that when communicating with our providers and staff our patients will be respectful and courteous. Patients who exhibit disrespectful, abusive behavior or inappropriate language will be discharged.

I am in receipt of the practice policies and am aware of my rights and responsibilities.

Patient Name: _____ Date: _____

Patient/Legal Rep Signature: _____

HIPAA Notice of Privacy Practices

Acknowledgement Form

By signing below, I acknowledge that I have been provided Premier Heart's Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information. Additionally, I have been given an opportunity to read the Notice.

Signature: _____ Date:_____

Print Name: _____

Signature of Authorized Representative: _____

Office use only:
If unable to obtain the patients' signature in acknowledgment of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc)

Patient Name: _____ Date: _____

Reason: _____

Medical Information Communication Preferences

Patient Name: _____ **DOB:** _____

As our patient we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as labs, tests results or appointments, to you and/or others involved in your care. Please note that appointment reminder "telephone calls or text" may be left at the contact number(s) or email you list below. Please list your email address to receive online healthcare information provided by Premier Heart patient secure portal or secure email.

Please indicate your communication preferences below:

By listing number(s)/or email(s) below you are giving Premier Heart permission to leave medical information pertaining to you, your dependent, or child.

Method	Area Code + Phone Number	Leave Voice Message or Email Please circle yes or no
Home Telephone		YES or NO
Mobile phone		YES or NO
Work phone		YES or NO
Email		YES or NO

Without specific permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relation to you (i.e. spouse, parent, son, daughter, partner, etc.) below if you would like medical information released to anyone other than yourself. Please check yes if a message with medical information can be left at the number you list below.

Name	Relationship (i.e. spouse, parent, son daughter, etc.)	Area Code, Phone #, extension	**OK** to leave a message
			Yes or No
			Yes or No
			Yes or No
			Yes or No
Comments:			

I assume the responsibility to inform the practice of any changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Legal Representative: _____ Date: _____

Print Signers Name: _____

PREMIER HEART

Authorization for Release of Information

Patient Name:		**Date of Birth:**
Address:		
City:	**State:**	**Zip Code:**

I authorize the use or disclosure of the above-named individual's health information as described below.

Treatment Dates:

Rendering Facility/ Office or Disclosure Facility/Office: _____
Address: _____
_____
Phone: _____
Fax: _____

The type of information to be used or disclosed is as follows:

_____ Treatment/ visit notes	_____ EKG	_____ Reports	_____ Medication lists
_____ Lab results	_____ Radiology Reports	_____ Consult notes	_____ Other

This information may be disclosed to and used by the following individual or organization:

Premier Heart, LLC

151 Fries Mills Road, Suite 105

Turnersville, NJ 08012

Office: 856-212-0130 Fax: 856-212-0135

I understand that information in my health record may include information relating to Human Immunodeficiency virus (HIV), AIDS (Acquired Immune Deficiency Syndrome), psychological or psychiatric conditions or treatment, sexually transmitted diseases or drug/alcohol, abuse/ dependence status, detoxification or rehabilitation services. I understand that I have the right to revoke this authorization at any time. I understand if I revoked this authorization I must do so in writing and present my revocation to Premier Heart. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, this authorization will expire in 1 year. I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign the form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____

PREMIER HEART

Name: _____ DOB:_____

Cardiovascular History:

	Yes	No	Date	Hospital/ Location
History of Heart Attack?				
Heart Catheterization or Coronary Angiogram?				
Coronary Balloon Angioplasty or Stent?				
Heart Bypass Surgery or CABG?				
Heart Valve Surgery?				
Electrophysiological Study? Example: Cardiac Ablation				
Pacemaker or Defibrillator? If yes: St Jude Medtronic Other				
Last Stress test?				
Last Echo?				

Close family member who currently have or had a history of heart disease, diabetes, or hypertension?

	Yes	No	Age of onset?	Heart, Blood Pressure, Diabetes, Other
Mother				
Father				
Brother/Sister				
Maternal grandparent				
Paternal grandparent				
Other:				

Smoking history: please circle below

Current	Former	Never	Quit date

Alcohol Use: please circle below

Daily amount:	Weekly amount:	Monthly amount:

Illegal Substance: please circle below

Current/ Substance	Former	Never	Quit date

Current Medications:	Directions
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Allergies to Medication: YES NO

If yes, please list and reaction:

Surgical History: YES NO

If yes, please list:

Hospitalizations: YES NO

If yes, please list:

Have you been diagnosed with any of the following or have any complaints listed below?

	Yes	No		Yes	No		Yes	No
High blood pressure:			High Cholesterol:			Palpitations		
Diabetes:			Chest pain, tightness, or heaviness			Heartburn		
Shortness of breath with activity			Do you wake up at night short of breath?			Do your legs and/ or ankles swell		
Kidney Disease			Varicose Veins			Heart Murmur		
Lung Disease: COPD/ Asthma			Pain in legs or buttocks when walking?			Blood clots in legs or lungs		
Fainting			Dizziness or Lightheadedness			Anxiety/ Depression		
Stroke			Unexplained weight loss			Seizures		
Mini Stroke (TIA)			Anemia			Thyroid Disease		
Blood disorder			Cancer			Colitis/ Crohns		
Other:								

Patient Signature/Legal Representative:

	Date: