Effective 11/20/2019

Dear Patients,

Our office is committed to providing quality medical care that emphasizes patient safety. Safe and accurate use of your medications is an important part of your health care.

Our Goals Include:

- To encourage and educate patients in safe and correct use of their medications.
- To reduce medication errors, interactions, and side effects.
- To improve care coordination of medication prescribing and use.

Key Medication safety points we would like you to follow include:

- **Bring in ALL medications to each visit.**
  Your physician and staff will review your medications at each visit, having the actual prescriptions bottles will ensure that the medication and dose are the correct ones. This can only be done if we have the actual prescriptions bottles available.

- **Keep medication in its original labeled bottle.**
  For your safety, please keep your new or refill medications in the containers they came in from the pharmacy. Do not combine with older pills. Please discard old or used bottles to avoid confusion.

- **Dispose of ALL outdated medications, medication bottles, and medication you no longer use.** If you are instructed by your physician to keep a medication you are not currently taking, clearly mark and seal the bottle to avoid taking it by mistake.

- **Bring ALL of your medication to consultant physician appointments, hospitals, emergency rooms, and urgent care centers.**
  Providing a list of your medications to other physicians, hospitals, and emergency rooms, will reduce the risk of duplicating medications, drug interactions, and allergies.

Thank You,

Heart MD, LLC

478-257-5533

404 Corder Road, Ste 400
Warner Robins, GA 31088
478-257-5533 phone 478-347-3115 fax

Medical Record Release Form

Patient Name: ____

Date Of Birth: ______________________

Patient Address

Street: ___________________________

City: ________________ State ___________ Zip: ___________

I hereby request and authorize the release of my entire medical records file for the purpose of continuation of care, to Heart MD, LLC.

Please fax the following records to 478-347-3115 or 866-834-3372.

Thank you

Patient Signature: ____

Requesting Records From: ___________________________________

Please send the following reports STAT to 478-347-3115 or 866-834-3372

____

____

____

____

____

____

404 Corder Road, Ste 400
Warner Robins, GA 31088
478-257-5533 phone 478-347-3115 fax

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Heart MD calls each patient and sends email reminders the day before every appointment, unless your appointment falls right after a holiday which we call a few days prior to your appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess the following fees:

- Office Visit with Doctor or Nurse Practitioner - **$25**
- Ultrasound - Echocardiogram, Carotid, AAA, ABI, Lower Venous & Lower Arterial - **$50**
- Stress Test - **$150**

The fees listed above will be charged to your account. The "no-show charge fees" are not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Heart MD and agree to provide payments billed to me for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

________________________________ ________________

Patient/ Guarantor Signature Date

404 Corder Road, Ste 400
Warner Robins, GA 31088
478-257-5533 phone 478-347-3115 fax

Procedure Record Release Form

Patient Name: ______________________________

Date Of Birth: ______________________

Street: ______________________________

City: ________________ State ____________ Zip: ______________

I hereby request and authorize the release of my entire medical records file for the purpose of continuation of care, to Heart MD, LLC.

Please fax the following records to 478-347-3115 or 866-834-3372.

Thank you

Patient Signature: ______________________________

Please put year, Hospital, and Dr. who performed procedure.

- CABG (Open Heart)______________________________
- TEE ______________________________
- CATH______________________________
- STRESS TEST______________________________
- ECHO______________________________
- CAROTID______________________________
- AAA STUDY______________________________
- LOWER VENOUS STUDY______________________________
- LOWER ARTERIAL STUDY______________________________
- CVA______________________________
- LABS______________________________
- STENT______________________________

Date: ____________________

Demographic Information

Patient Name: ____________________ DOB: ___/___/____ SS#____-____-____

Mailing Address: ____________________________________

City: ________________ State:_______________ Zip: ____________

Home Phone: (_____)_____-_____ Cell Phone: (___)_____-_____ Do you have texting capability? Y / N

Emailing Address: ____

Emergency Contact Name: ______________________ Relationship: _____________________

Emergency Contract Phone Number: ____________________________

Primary Care Physician: (Please specify physicians name, not place of practice)_________________

Pharmacy:__________________ Pharmacy Locations: ________________________________

Employment Status:	Policy Holder:	Marital Status:	Ethnicity:	Race:
♡ Full Time	♡ Self	♡ Married	♡ Non-Hispanic	♡ White
♡ Part Time	♡ Spouse	♡ Single	♡ Hispanic/Latino	♡ African American
♡ Unemployed	♡ Parents	♡ Divorced	♡ Refused to Report	♡ Asian
♡ Disabled				♡ Other
♡ Retired				

Insurance Information:

Primary Insurance: ____________________________________

Policy Number:____________________________ Group Number: ___________________________

If the policy is under anyone other than the patient:

Guarantor Name: _______________________ DOB: _______________ SS#: __________________

Secondary Insurance: _______________________________ Policy Number: ____________________

Group Number: _______________________

Patient Name: ______________________ DOB: ____________ Date: ______________

Reason for Your Visit Today: ____

Symptoms :(Please circle ALL that apply)

- Chills/ Fatigue/ Headache/ Lightheadedness
- Chest pain now/ Cough/ Coughing up blood/ Shortness of breath on exertion/ Wheezing
- Chest pain on exertion/ Dizziness/ Weakness/ Shortness of breath when sleeping flat/ Palpitations/ Shortness of Breath/ Chest pain at rest
- Constipation/ Diarrhea/ Heartburn/ Nausea/ Vomiting/ Joint Stiffness/ Leg pain or cramps/ Muscle aches/ Leg swelling

Medical History :(Mark Only the Ones That Apply)

- Diabetes (High Blood Sugar) Type 1 Type2
- Lung Disease (asthma, emphysema, bronchitis) Insulin (Shots) or oral meds (Pills)
- Kidney Disease
- Thyroid Disease
- Cancer (Any type)

Prior Heart Problems: Only Mark the Ones that Apply

Recent Hospitalization, where? ______________
Heart Attack, When? ______________
Cardiac Cath, When? ______________
Where? ______________
Angioplasty, When? ______________
Stent, When? ______________
Open heart surgery, When? ______________
Pacemaker or AICD
Enlarged Heart
Congestive Heart Failure (CHF)
Abnormal Stress Test
Abnormal EKG
Aortic Stenosis/ Mitral Valve Prolapse
Rheumatic Fever

Past Surgical History:

____
____
____
____

Social History: Only circle the ones that Apply

Smoker: Former Current Never
When did you quit? ______________
How many packs do you smoke a day? ______________
Alcohol Usage: Occasional Frequent
Exercise: None Very Little 3 or more times/wk
require assistance walking
Females:
Possibility of Pregnancy
Currently Breastfeeding
Family (Blood) History: Only mark the ones that Apply

Please Specify Paternal or Maternal

Any relative have a heart attack? What age?
____

Any relative have sudden cardiac death? What age? ______________________________
Any relative with heart problems? Who?
____
____

Compound Authorization for Release of Information:

Patient Name: ______________________________ DOB: ___/___/___

I hereby release all medical information to the following:

1. Name: ____
   Relationship: ____________________

   Contact Number: ______________________

2. Name: ____
   Relationship:____________________

   Contact Number: ______________________

3. Name: ____
   Relationship: ____________________

   Contact Number: ______________________

4. Name: ____
   Relationship: ____________________

   Contact Number: ______________________

Identity theft Prevention Policy: I hereby acknowledge that I have provided Heart MD with my correct proof of identification. I am also aware that they can ask me at any visit for my photo ID and current health insurance card. By signing this form, certify that I have read, fully understand, and will comply with this policy.

Authorization for Release of Information and consent to treat: I authorize Heart MD, LLC. To release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable disease) requested by my health insurance carrier, Medicare, or any other third- party payers. I authorize Heart MD, LLC to release all medical information to my referring and primary care physician. I authorize Heart MD, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health care plan administrator to release such information to Heart MD, LLC. I or my legal guardian authorizes Heart MD, LLC to provide medical care reasonable by today's standards.

Notice of Privacy Practices: I understand that there are copies of the Heart MD, LLC'S notice of privacy practices, available for my use, both at the front desk and posted in the lobby.

Signature of Patient or Legal
Guardian: ________________________________ Date: ______________________