HEART RHYTHM & VASCULAR
Specialists of Dayton

HEART, RHYTHM & VASCULAR SPECIALISTS OF DAYTON

NEW PATIENT PACKET

First Name: Middle Initial: Last Name:

SSN: Date of Birth: Age:

Gender: M / F Marital Status: Height / Weight:

Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email Address:

Employer: Employer Phone Number:

Emergency Contact: Relationship:

Emergency Phone:

Primary Care Physician:

Referral Source:

Pharmacy:

Authorization to Release information:

I hereby authorize Heart, Rhythm & Vascular Specialists of Dayton to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at my office visit and that fees are collected on the day of the visit. If for any reason it becomes necessary to render collection proceedings, I understand that I am responsible for all treatments, and services received, as well as all legal and collection fees that occur at Heart, Rhythm & Vascular Specialists of Dayton

Signature: Date:

HEART, RHYTHM & VASCULAR SPECIALISTS OF DAYTON

CONSENT FOR PURPOSES OF TREATMENT PAYMENT AND HEALTH CARE OPERATIONS

Prior to using or disclosing your protected health information (PHI) to carry out treatment, payment, or health care operations, we are required under federal law to obtain your consent.

I consent to Heart, Rhythm & Vascular Specialists of Dayton using or disclosing my PHI for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill, or conducting health care operations. I understand that if I fail to sign this consent, the physicians, and Heart, Rhythm & Vascular Specialists of Dayton may refuse to provide treatment or care for me.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment and/or payment to health care operations. Heart, Rhythm & Vascular Specialists of Dayton is not required to agree to these restrictions. However, if Heart, Rhythm & Vascular Specialists of Dayton agrees to a restriction that I request, the restriction is binding on Heart, Rhythm & Vascular Specialists of Dayton and the physicians of Heart, Rhythm & Vascular Specialists of Dayton.

I have the right to revoke this consent, in writing, at any time, except to the extent that Heart, Rhythm & Vascular Specialists of Dayton or the physicians Heart, Rhythm & Vascular Specialists of Dayton has taken action in reliance of this consent.

I understand I have the right to review Heart, Rhythm & Vascular Specialists of Dayton notice of privacy practices prior to signing this consent form. The notice of privacy practices gives a more complete description of the permissible uses and disclosures of my PHI. The notice of privacy practices is available upon request.

Heart, Rhythm & Vascular Specialists of Dayton reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised copy of privacy practices by calling the office and requesting a copy be sent by mail or given at the time of my appointment.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms set forth in this consent.

Signature of Patient or Personal Representative Date

Printed Name of Patient or Personal Representative

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INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ SSN: _____

Policy Holder's Relationship to Patient: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ SSN: _____

Policy Holder's Relationship to Patient: _____

Tertiary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ SSN: _____

Policy Holder's Relationship to Patient: _____

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ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government HER incentive program, this information will be added to your electronic record.

Patient Name: Date of Birth:

Email Address:

1. Preferred Method of Communication for Appointment Reminders (CHECK ONE):

   Phone _____ Email_____ Mail_____

2. Gender (CHECK ONE):

   Male _____ Female _____

3. Preferred Language: _____

4. Smoking Status (CHECK ONE):
   Every day smoker _____ Occasional Smoker: _____
   Former Smoker: _____ Never Smoked: _____

5. Race

   ___ American Indian
   ___ Alaska Native
   ___ Asian
   ___ Black or African American
   ___ White or Caucasian
   ___ Native Hawaiian
   ___ Pacific Islander
   ___ Other
   ___ I Decline to Answer

6. Ethnicity

   ___ Hispanic or Latino
   ___ Not Hispanic or Latino
   ___ I Decline to Answer