Cardiology & Arrhythmia Consultants PC

Anil K. Goel M.D. F.A.C.C.

1915 E 14 Mile Road
Birmingham, MI 48009
Phone 248-723-4777 Fax 248-723-4776

Please provide your information and personal history, with a list of medications.
For your identification protection insurance cards with a picture ID is required

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Last Name:_____First Name:_____

Birthdate:_____Sex: M F Married/Divorced/Single

Address:_____

City:_____State:_____Zip:_____Email:_____

Home Phone: (_____)_____ Mobile Phone: (_____)_____

Email: _____

Occupation: _____Retired *(circle)*: Y/N Retirement date:_____/_____/_____

Social Security Number:_____

Referring Physician:_____Phone: (_____)_____

Primary Care Physician:_____Phone: (_____)_____

If insurance is under spouse please provide the following:

Spouse's name:_____Birth date:_____

Employment group:_____ *(circle)* Full time / Part time / Retired

Emergency Contact

Name:_____Phone: (_____)_____

Relationship:_____

Can medical information be shared with this person? *(circle)* **Y / N**

Please note: if you have an HMO we must have a referral for the date of service to be seen or a signed waiver that you accept responsibility for denied services

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MEDICAL INFORMATION RELEASE AUTHORIZATION

PATIENT NAME:_____ DATE OF BIRTH:_____

By my signature below, I authorize the staff of:_____

Phone: _____ Fax:_____

To use and disclose my protected personal health information to the above addressed or:

_____

_____

Specific information to be used or disclosed (check below):

_____All Records

_____EKG _____Cardiac testing (circle): Echocardiogram / Stress Tests / Monitor Readings

_____All Labwork _____Pacemaker/ICD records ____Other: _____

The purpose of this disclosure is for continuity of Cardiac/Medical care: This expires in 12 months unless a written revocation is received. I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Privacy Officer of the sender of the information. I understand that a revocation is not effective until received by them and is not effective to the extent that the sender had previously acted in reliance on this authorization.

I acknowledge that I have read and understand this record release authorization:

_____ Date:_____

Signature of patient or legal guardian

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HIPPA POLICY AGREEMENT

By signing below you are authorizing Cardiology and Arrhythmia Consultants PC, to disclose information about you for:

- Ordering Laboratory tests and procedures, & calling to give you the results by phone
- Authorizing the office to release prescription information to pharmacies via fax/phone or electronic
- Use of your information to fulfill standard health operations to coordinate Your care with other providers and your insurance carriers for payment
- Appointment reminders and billing arrangements via phone

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Cardiology and Arrhythmia Consultants reserves the right to modify privacy practices, you will be notified of changes at your appointment. A copy of the "Notice of Privacy Policies & Practices" is posted and copies available.

I have reviewed this consent and HIPPA information and give my permission to Cardiology & Arrhythmia Consultants to use and disclose my health information in accordance with the contents of this agreement:

_____ Date: _____

Signature of patient or legal guardian
(Power of Attorney papers may be required)

Assignment of Benefits and Financial policy

I hereby assign to Cardiology and Arrhythmia Consultants PC, any insurance or other third party benefits available for health care services provided to me. I understand that Cardiology & Arrhythmia Consultants PC has the right to refuse or accept assignment of such benefits, and that I am responsible to understand my own insurance policies and will pay for uncovered services. I understand that verification of insurance and authorizations does not guarantee payment. If benefits are not assigned to Cardiology & Arrhythmia Consultants PC, I agree to forward to Cardiology & Arrhythmia Consultants PC all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. The information provided is accurate and true to the best of my knowledge:

_____ Date: _____

Signature of patient or legal guardian
(Power of Attorney papers may be required)

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HMO Beneficiaries

(skip if this does not apply to you)

In accordance with my insurance agreements I acknowledge I may not be seen if I come in to Cardiology and Arrhythmia Consultants PC for services without the appropriate authorization from my Primary Care Physician and I will pay for unauthorized services if I chose to be seen without obtaining proper authorization from my PCP:

_____ Date: _____

Signature of patient or legal guardian
(Power of Attorney papers may be required)

Skilled Nursing Facility Patients

(skip this if this does not apply to you)

Please provide the following information

Name of facility: _____

Address: _____ Phone: (____) _____

Primary caregiver at facility: _____ Phone: (____) _____

Please bring in paperwork authorizing services other than office visit if self/patient is under a Medicare Part A consolidated billing agreement.

Auto or Work Related

(skip this if this does not apply to you)

Name Of Auto/Company: _____

Address: _____

____/____/____ _____ (____) _____
Date Claim Number Representative Number

Please Complete/Update This Questionnaire

What Is The Major Concerns Which Brought You To The Office Today?

_____

_____

Major Concerns (check all that apply)

Chest Pain Or Tightness?	
Duration Of Chest Pain	
Shortness Of Breath?	
Shortness Of Breath With Exertion?	
Irregular Or Skipping Heart Beat?	
Lightheaded / Dizziness?	
Swelling Of Legs?	
Have Taken Nitroglycerin?	
Need To Sit To Breath?	
Rapid / Racing Heart	
Passing Out / Black Out Spells	
Pain In Arms	
Pain In Jaw / Neck / Shoulder	

History

Smoker? How Often? If quit, date?	/ /
Alcohol Consumption (if yes, how many servings per day?)	
Past or Present Use of Recreational Drugs	

Additional History (check all that apply)

Hypertension	
Heart Murmur	
Heart Attack *(if so, supply date)*	
Birth Control	
Heart Disease	
Hyper Cholesterol	
Rheumatic Fever	
Diabetes	
Lipidemia	

Other Medical Conditions

History Of Stroke (if so, when)	/ /
Alzheimer's	
Other Mental Impairment?	
Vision Disorders	
Hearing Impaired	
Thyroid Disease	
Lung Disease	
Stomach Or Intestinal Problems?	
Kidney Disease	
Osteoporosis	
Dialysis/ESRD (if yes, start date)	/ /
Renal Insufficiency	
Arthritis	
Cancer	
Frequent Infections	
Urinary Or Prostate Problems	
Blood Disorders	
HIV/AIDS	
Cirrhosis	
Gerd	
Hepatitis	
Gout	
Problem Pregnancies	
Other unlisted (please specify)	

Please Complete/Update This Questionnaire
(continued)

General Symptoms

Significant Weight Change Gained / Lost Since?	 _____ / /
Headaches Intensity? Duration?	 _____
Fever / Chills? Began?	 / /
Rash Location Duration	
Nausea / Vomiting	
Blood in Phlegm	
Burning or Difficult Urination	
Diarrhea Or Constipation	
Abdominal Pain Or Indigestion	
Blood In Urine	
Blood In Stool	
Changes In Stool Color	
Bone/Joint Pain	
Sleep Problems	
Apnea	
Cold / Heat Intolerance	
Depression	
Nervousness	
Persistent Cough	
Coughing Phlegm @ 2 Months In Year	
Other Unlisted	

Family History

Heart Disease *(if yes, list relation)*	
Hypertension *(if yes, list relation)*	
High Cholesterol *(if yes, list relation)*	
Sudden Cardiac Death	
Other *(if yes, list relation)*	

Medication List

(if you already have a list, just give it to office staff and we will fill in the information)

Medication Name	Dosage	Frequency

Allergies (medicine)
