Patient Information

Main: (919) 794-5450
Fax: (919) 794-5447
www.ncaaheart.com

Date:

Email:

Patient Name:

Physical Address:

City:

State: Zip Code:

Alt/PO Box:

City:

State: Zip Code:

SSN:

Date of Birth:

Sex: ☐ Male ☐ Female

Home Phone:

Mobile Phone: Work:

Marital Status

☐ Single ☐ Divorced

☐ Married ☐ Widowed

How did you learn about our practice?

☐ Referring Physician ☐ Magazine/Newspaper

☐ Television ☐ Radio ☐ Other

Employment Status

☐ Employed Employer:

☐ Unemployed Occupation:

☐ Retired

Would you like a copy of reports sent to your Primary Care Physician? ☐ Yes ☐ No

Referring Physician

Physician Name:

Address:

Phone:

Primary Care Physician

Physician Name:

Address:

Phone:

Insured Information

Name: Relationship to patient:

Date of Birth: SSN:

Insurance Information

Primary Insurance: Secondary Insurance:

Policy/Member ID: Policy/Member ID:

Group Number: Group Number:

Emergency Contact

Name: Home Phone:

Relationship: Work Phone:

The undersigned hereby assigns to North Carolina Arrhythmia Associates all rights, title and interest in any payment due and/or undersigned for medical care, services, or supplies described in any health-insurance claim form or statement issued by North Carolina Arrhythmia Associates. The undersigned understands that this agreement will not eliminate or effect in anyway the obligation of the patient and/or undersigned to pay North Carolina Arrhythmia Associates for all services and supplies rendered, including, nut not limited to, any co-payments or deductibles required by a particular health-care program or plan.

Patient Signature and Date

Release of Medical Information

I hereby authorize the releaser of any medical records, inclusive of all results of any testing and other pertinent information acquired during my treatment, to the physician as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Insured Signature and Date

Witness Signature and Date

Confidential Health History

Main: (919) 794-5450
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Name:		DOB:		Age:		SSN:	

Reason you are here:

If you are experiencing chest discomfort, when does it occur?

Describe the sensation:

How long does it last?

When did it start?

Please provide your past medical history (including surgery and hospitalizations):

Family Medical History			
Father	Living?	Heart Disease?	Stroke?
Mother	Living?	Heart Disease?	Stroke?
Grandparents	Living?	Heart Disease?	Stroke?
Brother/Sister	Living?	Heart Disease?	Stroke?
Aunt/Uncle	Living?	Heart Disease?	Stroke?
Children	Living?	Heart Disease?	Stroke?

Patient Cardiac Risk Factors	
High Blood Pressure	☐ Check if "yes"
Smoking	☐ Check if "yes"
Obesity	☐ Check if "yes"
Cholesterol	☐ Check if "yes"
Diabetes	☐ Check if "yes"
Family History	☐ Check if "yes"

Allergies	
Iodine	☐ Check if "yes"
Penicillin	☐ Check if "yes"
Seafood or Shellfish	☐ Check if "yes"

Other Reason(s) For Visit:	
Treadmill test	☐ Check if "yes"
Palpitations	☐ Check if "yes"
Rapid heartbeat	☐ Check if "yes"
Poor circulation	☐ Check if "yes"
Shortness of breath	☐ Check if "yes"
Swelling	☐ Check if "yes"
High Blood Pressure	☐ Check if "yes"
Heart murmur	☐ Check if "yes"
Rheumatic Fever	☐ Check if "yes"

Other (please list below):

Other Health History			
Abdominal Pain	☐ Check if "yes"	Heat/cold Intolerance	☐ Check if "yes"
Asthma	☐ Check if "yes"	Hepatitis	☐ Check if "yes"
Blackout	☐ Check if "yes"	Indigestion	☐ Check if "yes"
Claudication	☐ Check if "yes"	Liver/Gallbladder	☐ Check if "yes"
Constipation	☐ Check if "yes"	Numbness	☐ Check if "yes"
Cough	☐ Check if "yes"	Painful Urination	☐ Check if "yes"
Dizziness	☐ Check if "yes"	Phlebitis	☐ Check if "yes"
Emphysema	☐ Check if "yes"	Pneumonia	☐ Check if "yes"
Excessive Thirst	☐ Check if "yes"	Seizers	☐ Check if "yes"
Excessive Hunger	☐ Check if "yes"	Sinus Problem	☐ Check if "yes"
Fainting	☐ Check if "yes"	Sore Throat	☐ Check if "yes"
Head Injury	☐ Check if "yes"	Urgency/Hesitancy	☐ Check if "yes"
Headaches	☐ Check if "yes"	Varicose Veins	☐ Check if "yes"
Hearing	☐ Check if "yes"	Vision	☐ Check if "yes"
Heartburn	☐ Check if "yes"	Weight Gain/Loss	☐ Check if "yes"

Current Medications:

Social History							
Smoke?	☐ Check if "yes"	# per day:		Quit:	☐ Check if "yes"	Date quit:	
Alcohol?	☐ Check if "yes"	# per day:		Caffeine?	☐ Check if "yes"	# per day:	
Rec. Drugs?	☐ Check if "yes"	# per day:		Diet:			

NORTH CAROLINA
ARRHYTHMIA ASSOCIATES

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CONSENT TO THE USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

NAME: ____

BIRTHDAY: ____________________ SOCIAL SECURITY: __________________________

______(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

______ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

☐ I request the following restrictions to the use or disclosure of my healthcare information.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient:

Signature of Patient or Legal Representative Date Witness Signature

OFFICE USE ONLY:

☐ Accepted

☐ Denied

Signature Title Date

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_______ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is______________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is______________________________.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: ____

Patient/Patient Representative Signature: ____

Date: _____________________________ *Time:* ____________________

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: ____ Date: ___________________

Name: ____ Date: ___________________

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _________________________________ Date __________________________

NORTH CAROLINA
ARRHYTHMIA ASSOCIATES

Section A: This section must be completed for all Authorizations		
Patient Name:	**Birth Date:**	**Social Security No.** ***(optional)*****:**
Provider's Name:	**Recipient's Name:**	
Provider's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative Information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______________ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

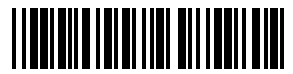
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**



ROI