CARDIOVASCULAR CONSULTANTS, P.C.

PLEASE PRINT

PATIENT INFORMATION

Please bring with you Picture ID, Insurance cards & Medication List

Patient Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____

Social Security # _____ Birth Date _____ Gender _____ Marital Status _____

Email Address _____ Referred by _____

Race White American Indian Asian
(circle one) Black or African American Other

Ethnicity Hispanic or Latino
(circle one) Not Hispanic or Latino

Language _____

How did you hear about us? _____

Employer's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Family Doctor _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Phone # _____ Local or Mail Order _____

Address or Main Cross Roads _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____

GUARANTOR INFORMATION (if different than above)

Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Gender _____ Relationship _____

Primary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS# _____ Birthdate _____

Secondary Insurance _____ Claims Address _____

Subscriber Name _____ City _____ State _____ Zip _____

Insurance ID _____ Group # _____ Subscriber SS # _____ Birthdate _____

AUTHORIZATION TO PAY BENEFITS: I HEREBY ATHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CARDIOVASCULAR CONSULTANTS, P.C., REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE CARDIOVASCULAR CONSULTANTS, P.C., TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____

CARDIOVASCULAR CONSULTANTS P.C.

1. Chief Complaint / Reason for Visit

Please describe the main reason for your visit today:

_____

_____

2. Cardiac Symptoms

Have you recently experienced any of the following? (Check all that apply)

☐ Chest pain or pressure ☐ Shortness of breath

☐ Palpitations or irregular heartbeat ☐ Dizziness or fainting

☐ Fatigue ☐ Swelling in legs or ankles

☐ Difficulty breathing while lying flat ☐ Awakening short of breath at night

☐ Other symptoms:

_____

3. Cardiac History

Please check all that apply:

☐ Hypertension (High Blood Pressure)

☐ Coronary Artery Disease / Heart Attack

☐ Congestive Heart Failure

☐ Arrhythmia / Irregular Heartbeat

☐ Atrial Fibrillation / Flutter

☐ Pacemaker or Defibrillator (Type: _____)

☐ Valvular Heart Disease

☐ Congenital Heart Disease

☐ Peripheral Artery Disease

☐ Other Heart Conditions: _____

4. Non-Cardiac Medical History

☐ Diabetes ☐ High Cholesterol ☐ Stroke / TIA

☐ Thyroid Disease ☐ COPD / Asthma ☐ Sleep Apnea

☐ Kidney Disease ☐ Liver Disease ☐ Anemia

☐ Cancer (Type: _____)

☐ Other: _____

5. Surgical History

Please list any surgeries and approximate dates:

_____

_____

_____

_____

6. Allergies

☐ No known allergies

☐ Allergies to medications (list):

_____

Reaction(s): _____

7. Family History

Has a close relative (parent, sibling, or child) had any of the following?

Heart Attack: ☐ Yes ☐ No Relation: _____ Age: _____

Stroke: ☐ Yes ☐ No Relation: _____ Age: _____

Heart Failure: ☐ Yes ☐ No Relation: _____ Age: _____

Sudden Cardiac Death: ☐ Yes ☐ No Relation: _____ Age: _____

High Blood Pressure: ☐ Yes ☐ No Relation: _____ Age: _____

Diabetes: ☐ Yes ☐ No Relation: _____ Age: _____

8. Social History

Tobacco/vape Use: ☐ Never ☐ Former

☐ Current — Packs/day: _____ Years: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Daily

Amount: _____

Recreational Drug Use: ☐ No ☐ Yes

Type: _____

Caffeine Intake: ☐ None ☐ 1–2 cups/day

☐ 3+ cups/day

Exercise: ☐ None ☐ Occasional ☐ Regular

Type/Frequency: _____

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9. Women Only:

History of Preeclampsia ☐ yes ☐ No

History of Toxemia of Pregnancy ☐ yes ☐ No

History of Gestational Diabetes ☐ yes ☐ No

History of miscarriage 2nd trimester ☐ yes ☐ No

10. Review of Systems (Check if currently present)

General: ☐ Weight loss ☐ Fatigue ☐ Fever ☐ Chills

Eyes: ☐ Vision changes ☐ Eye pain

ENT: ☐ Hearing loss ☐ Sore throat ☐ Nosebleeds

Heart: ☐ Chest pain ☐ Palpitations

Lungs: ☐ Cough ☐ Shortness of breath

GI: ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Heartburn

GU: ☐ Frequent urination ☐ Blood in urine

Musculoskeletal: ☐ Joint pain ☐ Swelling ☐ Muscle aches

Neuro: ☐ Headache ☐ Dizziness ☐ Numbness

Skin: ☐ Rash ☐ Easy bruising

Psych: ☐ Depression ☐ Anxiety

11. Medications

List all current medications, vitamins, and supplements:

12. Additional Information or Concerns

Patient Signature: _____

Date: _____

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Authorized Personnel to Receive Communication

Patient Name: _____
Date of Birth: _____
Phone Number: _____

Purpose:

This form allows you to identify individuals (such as family members, caregivers, or others) who may receive information about your medical condition, treatment, or billing from **Cardiovascular Consultants, PC**.
We will not release your health information to anyone unless authorized by you or required by law.

Authorized Individuals

Please list the person(s) you authorize us to speak with regarding your care or billing:

Name	Relationship to Patient	Phone Number	Type of Information Authorized (Check all that apply)
_____	_____	_____	☐ Medical ☐ Billing ☐ All
_____	_____	_____	☐ Medical ☐ Billing ☐ All
_____	_____	_____	☐ Medical ☐ Billing ☐ All

Patient Signature

By signing below, I authorize Cardiovascular Consultants, PC to release my protected health information to the individual(s) listed above in accordance with this authorization.

Patient Signature: _____
Date: _____

CARDIOVASCULAR CONSULTANTS P.C.

Financial Policy

Purpose

Thank you for choosing Cardiovascular Consultants, PC for your cardiovascular care. We are committed to providing you with the best possible treatment. Please take a few moments to review our financial policy to ensure a clear understanding of your responsibilities.

Insurance

- We participate with many insurance plans. It is your responsibility to know your specific plan's benefits, requirements, and restrictions.
- Please bring your insurance card(s) and photo ID to each visit.
- If your insurance plan requires a referral or authorization, it must be obtained prior to your appointment.
- You are responsible for any services not covered or denied by your insurance carrier.

Co-Payments, Deductibles, and Balances

- All co-pays and outstanding balances are due at the time of service.
- We accept cash, check, and most major credit cards.
- Balances not paid within **30 days** of billing may incur late fees or be referred to collections.

Self-Pay Patients

- Patients without insurance coverage are required to pay in full at the time of service unless prior arrangements have been made.

CARDIOVASCULAR CONSULTANTS P.C.

Missed Appointments / Cancellations

- If you cannot keep your appointment, please notify us at least **24 hours in advance**.
- Repeated missed appointments may result in dismissal from the practice.

Returned Checks

- A **$35 fee** will be charged for any returned checks.

Forms and Medical Records

- There may be a fee for the completion of medical forms, FMLA paperwork, or the copying of medical records in accordance with state and federal law.

Assignment of Benefits

By signing below, I authorize payment of medical benefits directly to **Cardiovascular Consultants, PC** for services rendered.
I understand that I am financially responsible for all charges not covered by insurance.
I have read, understand, and agree to the financial policy above.

Patient Name (Print): _____
Patient Signature: _____
Date: _____

CARDIOVASCULAR CONSULTANTS P.C.

NOTICE OF PRIVACY PRACTICES

Cardiovascular Consultants, PC
Phone: 586-698-1200 **Fax:** 586-698-1210
Effective Date: November 2025

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by law to:

- Maintain the privacy and security of your protected health information (PHI).
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice.
- Not use or share your information other than as described here unless you tell us we can in writing.

Your Rights

You have the right to:

- **Get a copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record.
- **Ask us to correct your record:** If you think information is incorrect or incomplete, you can request a correction.
- **Request confidential communications:** You may ask us to contact you in a specific way (e.g., home or office phone).

CARDIOVASCULAR CONSULTANTS P.C.

- **Ask us to limit what we use or share:** You can request limits on how we use or share information for treatment, payment, or operations.
- **Get a list of disclosures:** You can request a list (accounting) of times we've shared your health information for up to six years prior to the date of your request.
- **Get a copy of this notice:** You can request a paper or electronic copy of this notice at any time.
- **Choose someone to act for you:** If you have given someone medical power of attorney, that person can exercise your rights.
- **File a complaint:** If you feel your rights have been violated, you may contact our Privacy Officer or file a complaint with the U.S. Department of Health and Human Services (HHS). You will not be penalized for filing a complaint.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Treatment

We can use your information and share it with other professionals who are treating you.
Example: Sharing test results with your primary care physician.

Payment

We can use and share your information to bill and get payment from health plans or other entities.
Example: Sending details to your insurance company for payment approval.

Health Care Operations

We can use and share your information to run our practice, improve your care, and contact you when necessary.
Example: Using data to evaluate the quality of care we provide.

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Other Ways We May Use or Share Your Information

We may also share your information about:

- Public health and safety issues (disease control, product recalls, etc.)
- Health oversight activities (audits, investigations, compliance)
- Legal and law enforcement purposes
- Organ and tissue donation requests
- Medical examiner or funeral director needs
- Workers' compensation, law enforcement, or government requests
- Responding to lawsuits and legal actions

Our Privacy Contact

Ashley Zito

Clinical Office Manager

Privacy Officer
Cardiovascular Consultants, PC
Phone: 586-698-1200 Fax: 586-698-1210

Changes to This Notice

We may change this notice, and the new notice will apply to all information we have about you. The new notice will be available on request and posted in our office and on our website (if applicable).

CARDIOVASCULAR CONSULTANTS P.C.

Patient Acknowledgment of Receipt of

Notice of Privacy Practices

Cardiovascular Consultants, PC
Phone: 586-698-1200 Fax: 586-698-1210
Effective Date: November 2025

I acknowledge that I have received a copy of **Cardiovascular Consultants, PC's Notice of Privacy Practices**.
This notice describes how my health information may be used and disclosed, and how I may access this information.

Patient Name (Print): _____

Date of Birth: _____

Patient Signature: _____

Date: _____
