REGISTRATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Preferred Phone Number _____ Alternate Phone Number _____

Email Address _____

Date of Birth ___/___/___ Gender _____ Social Security Number _____

Pharmacy Name _____ Pharmacy Phone Number _____

Pharmacy Address _____

Who referred you to our practice? _____

Primary Care Physician's Name _____ Phone Number _____

Primary Care Physician's Address _____ Fax Number _____

Emergency Contact Name and Phone Number _____

INSURANCE INFORMATION (Please allow the receptionist to photocopy your insurance and ID cards)

Primary Insurance

Plan Name _____ Insured's Name _____

Policy ID# _____ Group# _____ Insured's Date of Birth ___/___/___

Secondary Insurance

Plan Name _____ Insured's Name _____

Policy ID# _____ Group# _____ Insured's Date of Birth ___/___/___

HARMONY HEART GROUP

PATIENT HISTORY

Name _____ Date of Birth ___/___/___ Gender _____ Today's Date ___/___/___

WHY ARE YOU HERE TO SEE A CARDIOLOGIST?

History at Present (choose all that apply)

☐ Heart attack	☐ Palpitations/irregular heart beat	☐ Dizziness
☐ Angina	☐ Leg cramps when you walk	☐ Swollen legs
☐ High blood pressure	☐ Enlarged heart	☐ Heart failure
☐ Blue lips or fingernails	☐ Chest pain or pressure	☐ Heart murmur
☐ Shortness of breath	☐ Abnormal rhythm	☐ Fainting
☐ High cholesterol	☐ Diabetes	☐ Overweight

Are you a current smoker? ☐ Yes ☐ No If yes, how many cigarettes on an average day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what type and frequency? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, what type and frequency? _____

Has a close family member had

Heart attack?	☐ Mother	☐ Father	☐ Siblings
Angina?	☐ Mother	☐ Father	☐ Siblings
Bypass surgery?	☐ Mother	☐ Father	☐ Siblings
Carotid surgery?	☐ Mother	☐ Father	☐ Siblings
Surgery on leg arteries?	☐ Mother	☐ Father	☐ Siblings
Diabetes?	☐ Mother	☐ Father	☐ Siblings
High blood pressure?	☐ Mother	☐ Father	☐ Siblings
High cholesterol?	☐ Mother	☐ Father	☐ Siblings

Are you being treated now or have you been treated for any illnesses? (please list below)

_____

_____

Have you had any operations? (please list below)

_____

_____

Social History

What is your marital status? ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Number of children and gender _____

Occupation and major hobbies _____

HARMONY HEART GROUP

PATIENT HISTORY

Name _____ Date of Birth __/__/____ Gender _____ Today's Date __/__/____

REVIEW OF SYSTEMS (choose all that apply)

Nose/Throat/Mouth
- ☐ Nosebleeds
- ☐ Trouble swallowing

Ears
- ☐ Ringing in ears
- ☐ Difficulty hearing

Eyes
- ☐ Glaucoma

General
- ☐ Fatigue
- ☐ Weakness

Respiratory
- ☐ Chest congestion
- ☐ Cough
- ☐ Hemoptysis (coughing up blood)
- ☐ Lung problems
- ☐ Pain when breathing
- ☐ Shortness of breath
- ☐ Wheezing

Constitutional
- ☐ Chills
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Headache
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

Dermatologic
- ☐ Hives
- ☐ Rash

ENT
- ☐ Change in voice
- ☐ Cold
- ☐ Cough
- ☐ Epistaxis (nose bleeds)

Cardiovascular
- ☐ Changes in exercise tolerance
- ☐ Chest pain
- ☐ Chest pain while asleep
- ☐ Chest pain while awake
- ☐ Claudication
- ☐ Cold extremities
- ☐ Cold change in extremities
- ☐ Cyanosis
- ☐ Dizziness
- ☐ Shortness of breath on exertion
- ☐ Fainting
- ☐ Fatigue
- ☐ High blood pressure
- ☐ History of heart attack
- ☐ Known coronary artery disease
- ☐ Irregular heartbeat
- ☐ Lightheadedness
- ☐ Murmur
- ☐ Near syncope
- ☐ Orthopnea
- ☐ Pacemaker
- ☐ Pain in legs while walking
- ☐ Pallor
- ☐ Palpitations
- ☐ Swelling of ankles
- ☐ Varicose veins

Female Reproduction
- ☐ Contraception
- ☐ Pregnant

Male Reproduction
- ☐ Contraception
- ☐ Diminished sexual drive
- ☐ Erectile dysfunction

Gastrointestinal
- ☐ Ulcers
- ☐ Black or tarry stool
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Endocrine
- ☐ Cold intolerance
- ☐ Diabetes
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Low blood pressure
- ☐ Polydypsia (excessive thirst)
- ☐ Polyuria (excessive urinating)
- ☐ Sleep disturbance

Hematological
- ☐ Abnormal bleeding
- ☐ Abnormal clotting
- ☐ Bleeding
- ☐ Easy bruising
- ☐ Swollen glands

Musculoskeletal
- ☐ Gout
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Muscle aches
- ☐ Muscle weakness

Neurologic
- ☐ Gait abnormality
- ☐ Insomnia
- ☐ Numbness/tingling
- ☐ Tremor

Ophthalmologic
- ☐ Blurring of vision
- ☐ Diminished vision

Psychology
- ☐ Anxiety
- ☐ Depression
- ☐ High stress level

Urologic
- ☐ Difficulty urinating
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Frequent urination

PATIENT HISTORY

Name _____ Date of Birth ___/___/___ Gender _____ Today's Date ___/___/___

PATIENT TO COMPLETE BELOW

Please tell us about your medications (names, doses, frequency).
Please include over-the-counter medications and herbal medicines.

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Please list all allergies _____

Have you ever had a reaction to contrast dye? (i.e., Myelogram, kidney series, CAT scan) ☐ Yes ☐ No

Are you allergic to iodine, shrimp or shellfish? ☐ Yes ☐ No

POLICIES

PATIENT NO-SHOW/LATE CANCELLATION POLICY

Harmony Heart Group receives numerous cancellations and no shows on a daily basis from people with scheduled appointments. To help assure that patients have access to care when they need it, Harmony Heart Group charges a $50 fee for no-show and late-cancellation appointments. All appointments must be cancelled 24 hours prior to the appointment time (or by noon on Friday for a Monday appointment) to avoid these charges. There will be a fee of $150 charged to you for any of our Nuclear Medicine studies for no-show/late cancellation appointments, as there is a cost for the medication that we have purchased to use in these tests.

FINANCIAL POLICY STATEMENT

In order to prevent confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT TIME OF SERVICE. For your convenience we accept cash, check, Visa, MasterCard, and Discover. Your insurance policy is a contract between you and your insurance company; the doctor is not involved. We, too, have a contract with your insurance company, which dictates what we charge you and how we collect it. As a courtesy to our patients, we will bill contracted insurance plans directly. Any co-payment and/or co-insurance or deductible is payable at the time of service. I understand that if the provider and practice are not paid in full, or payment is denied, I will be responsible for payment of all services. Past Due accounts will result in the account being sent to our collections agency. Patient agrees to pay collections cost at an additional 30% of total balance on each account sent to collections. Any patient sent to collections will be dismissed from the practice until their balance is paid in full. No services will be rendered by the office (appointment or prescription refills) until the balance is paid in full.

PROVIDER POLICY

On your first visit you will see the physician. However, on subsequent visits, you will alternate with the doctor and nurse practitioner. If you have a preference, please let the office staff know prior to your appointment time; otherwise, this may delay your appointment time or even require it to be rescheduled. The nurse practitioner works in close collaboration with the doctor, and therefore will be aware of your condition at all times.

PRESCRIPTION REFILLS

If you need medication refills, please contact our office at least 48 hours in advance if possible. Ideally, it is best to notify Harmony Heart Group or your pharmacy a week before you take your last pill. Refills cannot be filled after 12PM on Friday or during other non-office hours.

I have read and understand the policies.
I also understand these policies may be amended from time to time by the practice.

Signature of patient **Date**

Name of patient (please print)

HARMONY HEART GROUP
HARMONYHEARTGROUP.COM ☎ 972.612.4730
🖷 972.398.9229

HARMONY HEART GROUP

POLICIES

PATIENT AUTHORIZATION AND PERSONAL REPRESENTATIVE

Patient's Name (please print) _____ Date of Birth ___/___/___

Purpose of Request: I authorize Harmony Heart Group to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purpose of receiving all PHI about me. As my designated personal representative, they may exercise my right to inspect, copy and correct my PHI. They may also consent or authorize the use or disclosure of my PHI. This authorization will remain effective until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by a court of law. We have no control over the person(s) you have listed as your personal representative. Therefore, our PHI discloses under the authorization will no longer be protected by the requirements of the privacy rule and will no longer by the responsibility of Harmony Heart Group.

_____ _____

Name of Personal Representative and Relationship **Phone Number**

_____ _____

Signature of patient **Date**

CONSENT FOR VOICEMAIL

I certify and understand the privacy risks of the mail, phone calls and e-mail.

☐ I do ☐ I do not authorize Harmony Heart Group and staff to leave a message concerning my medical care or appointment reminders on my telephone.

_____ _____

Signature of patient **Date**

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by Harmony Heart Group. I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

_____ _____

Signature of patient **Date**

POLICIES

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing the form, you acknowledge you have read the **Notice of Privacy Practices of Harmony Heart Group** located in our waiting area. Our **Notice of Privacy Practices of Harmony Heart Group** provides information about how we may use and disclose your protected health information and your rights related to the Use and Disclosure of your protected health information. We encourage you to read it in full. Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by requesting a copy from our office: Harmony Heart Group, 1600 Coit Rd., Suite 304, Plano, Texas 75075 \ 972.612.4730 (phone) or 972.398.9229 (fax). If you would like a copy of the **Notice of Privacy Practices** that you have just read, please advise our office staff. If you have any questions about our **Notice of Privacy Practices**, please contact the Privacy Officer at the number listed above.

I acknowledge I have had the opportunity to read the **Notice of Privacy Practices of Harmony Heart Group**.

Signature of patient or Authorized representative **Date**

MEDICAL RELEASE OF INFORMATION

☐ I do ☐ I do not authorize Harmony Heart Group to release medical records to my primary care physician and referring physician on file. I understand that I have the right to revoke this authorization at any time.

Signature of patient or Authorized representative **Date**