Delaware Heart & Vascular, P.A.

NEW PATIENT QUESTIONNAIRE

Name: ______________________________ **Age:** _____________ Date: ________________

Reason(s) for your visit today: ____

Other physicians you have seen: ____

____

Past History: *(Please include all health issues such as asthma, diabetes, heart disease, high blood pressure, etc.)*

____

____

Operations / Surgical procedures: *Please list all operations you have had such as heart bypass, angioplasty, cardiac catherization, appendix removal, etc.*

____________________ Year ________________________ Year _________________________ Year

____________________ Year ________________________ Year _________________________ Year

Allergies: *Please place a check next to any of your known allergies*

___ Aspirin ____ Codeine ___ Penicillin ___ Anesthetics ___ Demerol ___ Sulfa Drugs

___________________________ Not listed

Do you smoke? ___ Yes ___ No **Have you ever smoked?** ___ Yes ___ No

If yes, at what age did you start? _______ Age **when you quit:** _____ How **many years did you smoke?** _____

Medications: *Please list ALL medications you currently take (including those not prescribed such as herbal drugs), the dosage and how many times per day you take them. For example: Toprol XL 50mg one tab daily*

____

____

____

____

How much aspirin do you take daily? *(If any)* ____________________________

Do you take birth control pills? __________________

What are your hobbies and activities? ____

Do you exercise? ___ Yes ___ No **If yes: what do you do and what is the frequency?** __________________

____

NEW PATIENT QUESTIONNAIRE

Please check any problems you are having currently:

___ Headaches
___ Seizures
___ Numbness in hands or feet
___ Difficulty in balance
___ Dizziness
___ Fainting
___ Ringing in ears
___ Difficulty hearing
___ Double vision
___ Excessive sneezing
___ Nasal congestion
___ Shortness of breath
___ Nose bleeds
___ Swelling of feet or ankles
___ Palpitations of the heart
___ Chest pain or tightness
___ Change in shoe size
___ High cholesterol
___ Excessive thirst
___ Chronic fatigue
___ High blood pressure
___ Swelling of the legs
___ Cough
___ Coughing up blood
___ Wheezing
___ Night sweats
___ Fever more than 5 days
___ Difficulty swallowing
___ Vomiting
___ Anxiety / Nervousness
___ Diarrhea
___ Constipation
___ Bloody bowel movements
___ Black bowel movements
___ Abdominal pain
___ Jaundice
___ Hemorrhoids
___ Weight loss
___ Weight gain
___ Loss of appetite
___ Trouble sleeping
___ Difficulty thinking
___ Frequent urination
___ Pain with urination
___ Blood in urine
___ Reduction in urine
___ Difficulty urinating
___ Leakage of urine
___ Stiff neck
___ Back pain
___ Pain in legs when walking
___ Joint pain
___ Loss of hair
___ Skin rash
___ Dry skin
___ Hives
___ Itchiness
___ Pain with intercourse
___ Mood swings
___ Drug use ____________________
___ Alcohol use __________________

Family History: *Please include age, health status and cause of death if deceased:*
Father: (___ Living ___ Deceased) ____
Mother: (___ Living ___ Deceased) ____
Brother(s): (___ Living ___ Deceased) ____
Sister(s): (___ Living ___ Deceased) ____

Anything else we should know about your health history? ______________________________
____
____
____
____
____

Delaware Heart & Vascular, P.A.

Patient Name: ____ **Date:** _____________
Last First Middle

Mailing Address: ____________________________ **City:** _______________ **State:** _____ **Zip:** ________

Date of Birth: ____________ **Social Security No.:** _____________________

Home Phone: (___) ______-_______ **May we leave a message?** ___YES ____NO

Cell Phone: (___) ______-_______ **May we leave a message?** ___YES ____NO

Gender: ___Male __Female **Marital Status:** ___Married ___Single ___Widowed

Race: ____African American ____Asian ____Caucasian ____Native American ____Pacific Islander ____Decline to answer

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Decline to answer

Primary Care Physician: _______________________ **Referring Physician:** ____________________

Employer: _____________________________________ **Work Phone:** (___) ______-_______

May we call you at work? ___YES ___NO **May we leave a message** ___YES ____NO

Who may we contact in an emergency? Name: __________________ **Relationship:** ______________

Home Phone: (___) ______-_______ **Cell Phone:** (___) ______-_______ **Work Phone:** (___) ______-_______

Please read and sign all statements below:

Patients are responsible for the services rendered. Necessary forms (including referrals) will be completed to help expedite insurance carrier payments, however, YOU are ultimately responsible for all fees, regardless of insurance coverage. It is also required that payment for co-payments is rendered *at the time of service*. I understand that if incorrect or improper insurance information or referrals are not obtained for my visit(s), my appointment may be cancelled and I may be billed for the amount(s) due on the account.

Patient Signature ____ **Date** ________________

I request that payment of authorized Medicare/Other Insurance company benefits be made directly to Delaware Heart and Vascular, P.A. on my behalf for any services furnished to me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature ____ **Date** ________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims /other Insurance Company claims. I understand that any or all of my medical information may be used for blinded-data research, in which none of the date will be linked to my identity. I understand that my medical information may be electronically submitted to any or all of my treating physicians, hospitals and/or medical insurance benefits to the party who accepts assignment.

Patient Signature ____ **Date** ________________

Delaware Heart & Vascular, P.A.

Insurance Information

Please list ALL insurance plans you have coverage under.

Reminders:

All required referrals are the patient's responsibility. We will assist as needed.

If your insurance changes, please notify our office immediately.

PRIMARY INSURANCE: ____

Policy # ______________________ **Group #:** ___________

Policy Holder's Name: _____________________ **DOB:** ____________

Does your insurance require referrals? ___YES ___NO Co-Payment: $________

SECONDARY INSURANCE: _____________________________________

Policy # ______________________ **Group #:** ___________

Policy Holder's Name: _____________________ **DOB:** ____________

THIRD INSURANCE: ____

Policy # ______________________ **Group #:** ___________

Policy Holder's Name: _____________________ **DOB:** ____________

Note: Your personal and health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in your electronic chart in our office. If a claim is submitted to insurance, your health information on this form may be shared with the payer as per federal guidelines.

Delaware Heart & Vascular, P.A.

Notice of Privacy Practices Acknowledgement

My signature below only acknowledges receipt of Delaware Heart & Vascular P.A.'s Notice of Privacy Practices, *effective date May 1, 2006*

(You may request a copy of our Notice of Privacy Practices or there is a copy of it in our waiting room for your convenience.)

____
Name of Patient (Print)

______________________________ ________________
Signature of Patient **Date**

______________________________ ________________
Name of Representative if patient unable to sign **Relationship to patient**

______________________________ ________________
Signature of Representative **Date**

Authorization to Release Information

I hereby authorize Delaware Heart & Vascular, P.A. to release any information, including, but not limited to medical, appointment, billing, etc., to the following person(s):

(If you do not list anyone, we will not be able to speak to anyone other than you, the patient.)

______________________________ ________________
Name **Relationship to Patient**

______________________________ ________________
Name **Relationship to Patient**

____________ Patient/Representative declined to sign ________
Date

Delaware Heart & Vascular, P.A.

General Office Policies:

__Co-pays__ are expected at the time of service for all office visits.

__Insurance:__ We participate with most insurance plans. If you have any questions concerning our participation, please call our billing company, ***Twin Hearts Management,*** at 302-777-5700 **prior** to your scheduled appointment.

Knowing your insurance benefits including eligibility, covered benefits, and medically necessary procedures is **your responsibility**. Please contact the customer service department at your insurance company for questions regarding coverage.

You are responsible for any charges not covered by your plan. If we do not participate with your insurance company, **payment in full** is required at the time of service unless other payment arrangements have been made in advance. ***__For your convenience, Visa,__*** *__MasterCard, American Express and Discover are accepted, in addition to cash, checks and debit cards, as methods of payment.__*

__Payment Plans__ are available. Once a Payment Plan Arrangement has been set up, you are legally obligated to make payments on time according to the agreement. If you fail to make a payment, your account will immediately be turned over to our Business Associate, ***First Collect*** for collections processing.

__Collections:__ If your account is turned over to collections, you will need to satisfy your account balance with ***First Collect***, our Business Associate, before you can be seen by us**. You will be responsible for any collection and attorney fees that are incurred to collect your debt.** They can be reached at 302-674-1735.

__Updates:__ If your address, phone number or insurance changes, it is **your responsibility** to update your information with us. Some insurance companies require referrals or authorizations for specific appointments or testing. **If we do not have the correct information and your visit or testing is not authorized you will be responsible for any balance due.**

__Testing:__ If you are scheduled for testing, we do not collect a copay at the time of testing. We will bill your insurance company and they will notify you, as well as our office if we need to collect a copay, co-insurance or a deductible. You may receive a bill for your co-pay/co-insurance or deductible depending on your insurance plan's guidelines. **Please do not bring children to your appointment or your test will have to be rescheduled and you will be responsible for a no show fee.**

__Prescription refill requests__ may take up to 48 hours. It is best to call 1 week ahead of time for refills to ensure you have your medication when you need it. When calling in for your refill request, be sure to leave a message on **your doctor's Medical Assistant's voicemail**, should they not answer their phone. Leaving a message or request on the wrong extension may delay your refill. Return calls for all voice messages left by 4pm will be done that day. Return calls for messages left after 4pm will be returned the next business day.

__Prior authorizations for medications__ require 48 hours' notice.

__Missed Appointment Policy__: You will be charged a **Missed Appointment Fee** if you fail to notify our office within 24 hours of your scheduled appointment. __Our office has an answering service and they will take a message for you should you call the office after hours. All incoming calls accepted by the service are logged and if you do not leave a message with them, there is no record of your call.__ The charge assessed for any missed appointment fee ***is due on or before your next visit***.

Missed appointment fees are as follows:	
New patient	$50
Established	$25
Nuclear stress testing	$50
All other testing	$25

_________ Patient Initials

General Office Policies 07.13.16

General Office Policies:

Forms: There is a $25 fee to have a form completed by our office. A physician will determine if you need to be seen, or if the form can be completed without a visit.

Non-Compliant Patients Policy: In order for our practice to provide you with the proper cardiac care, our patients are responsible for following through for all testing or appointments discussed at your visit. If you do not show for an appointment with your physician/physician assistant 3 times, you will be discharged from our practice. We take your cardiac care needs seriously and insist you do as well.

Requests for Medical Records: Unless there is a clinical urgency, all requests for medical records are handled by our Business Associate,

Star Med, LLC. (302-235-5757)

A HIPAA Compliant Authorization Form must be completed in its entirety, and payment received **prior to the release of records**. We charge a fee for copies of your medical records using the fee schedule published by the State of Delaware. *(Please see below for fees)*

Medical Records Fees

"The fees that a practice may charge Delaware patients for copies of the patient's medical records are limited by a rule that was effective November 11, 2009. The fee limits apply regardless of whether the practice provides the copies directly to the patient or to another physician. The limits also apply to both electronic and paper copies.

$2.00 per page for pages 1-10
$1.00 per page for pages 11-20
$0.90 per page for pages 21-60
$0.50 per page for pages 61 and above

In addition to the fees above, practices may charge the following:

- *When the records are mailed, practices may charge the actual cost of postage or shipping.*
- *When the type of record requested cannot be photocopied (such as radiology films or fetal monitoring strips), practices may charge the cost of reproducing the records.*

Practices may require payment of all costs in advance of releasing the records except for records related to an application for a disability benefits program. For the complete rule, see Section 16.0 of the Rules and Regulations of the Board of Medical Licensure and Discipline"

Walk-ins are not accepted. Patients will be given an appointment as soon as possible, based upon clinical urgency.

Should we be closed due to inclement weather please visit our website at **www.deheartandvascular.com** or check with our answering service at our main number, ***302-734-1414,*** prior to coming in for your visit.

By signing this form I, ______________________________, acknowledge that I have read and understand the above office polices of Delaware Heart & Vascular, P.A. and that I will abide by these policies.

______________________________ ______________
Patient Signature Date

Delaware Heart & Vascular, P.A.

IQ HEALTH PORTAL

WELCOME TO YOUR SECURE PATIENT PORTAL

Dear Patient:

Delaware Heart & Vascular, P.A. is excited to offer you ***IQ Health***, a secure Patient Portal. By accessing our Patient Portal you will be able to have web-based interactions with our office. You will be able to do the following:

Request Medication Refills
View specific lab results
Access your personal health record
Download your personal health record

In order to access our Patient Portal, you will need to provide your email address and last four digits of your social security number, which will be used as your login and initial password. You will then receive an email invite from IQHealth.com. Once you receive the email, simply click on the link and follow the prompts to activate your account.

If you are not interested in having web-based access at this time, you can continue to contact the office via telephone or mail.

If you change your mind in the future just let us know and we will be glad to send you an invite.

We hope you will take advantage of our Patient Portal. It's a fast and easy way to communicate with our staff. If you have any questions or concerns, please contact our office for assistance.

Thank you,
Delaware Heart & Vascular, P.A.

_______ **YES**, sign me up for the Patient Portal _______ **No**, I do not wish to participate at this time

Please print the following:

Patient Name: ____________________ **DOB:** ____________

Email address: ____________________ **Last 4 digits of SSN:** ________

Signature: ____________________ **Date:** __________

Patient Portal Invite 07.14.16