Chesapeake and Washington Heart Care

Thank you for choosing Chesapeake and Washington Heart Care, P.C.

We feel privileged that you have chosen our dedicated team of physicians to meet your cardiology needs. You can visit us at www.Chesheart.Com

Attached are the forms necessary to complete your chart. For your initial visit you will need to bring the following with you:

1. Your insurance card(s)
2. Your picture ID
3. A list of current medication you are taking.
4. The attached forms filled out and signed. Please note: if you do not have these forms filled out when you arrive, you could be asked to reschedule.
5. Your referral from your primary care physician as well as any blood work, EKG results, surgery reports and other pertinent information regarding the reason for your visit.
6. Your co-payment or coinsurance is due at the time of your visit.
7. You need to arrive at least 15 minutes early so that we may process your paperwork. Please note: If you are late you could be asked to reschedule.
8. Patients that do not call in advance to cancel or do not show their first will not be rescheduled unless the referring physician's calls to request another appointment.

If you have any questions, please feel free to contact our Waldorf office at (301)645-5100 or our Leonardtown office at (301) 475-3240. Chesheart@aol.com

We look forward to meeting you!

CHESAPEAKE AND WASHINGTON HEART CARE, PC

PATIENT INFORMATION

NAME: ______________________________________
LAST FIRST MIDDLE

DATE OF BIRTH:___/____/____ SEX: M / F

MARITAL STATUS:________ SSN:_______________

ADDRESS:___________________________________

CITY/STATE/ZIP:_____________________________
PHONE:________________ _/______________________

PATIENT EMAIL:______________________________
OCCUPATION: ________________________________

EMPLOYER: _________________________________

EMPLOYER ADDRESS:_________________________
____

EMPLOYER PHONE:___________________________

POLICY HOLDER INFORMATION: ____________________
____:
RELATIONSHIP TO PATIENT: _____________________
(IF SELF, SKIP TO PRIMARY DR.)
NAME:________________________ DOB: ____/____/_____

ADDRESS____

CITY/STATE/ZIP:__________________________________

EMPLOYER:______________________________________

PHONE;____

PRIMARY DR:_____________________________________
PHONE NUMBER:__________________________________

REFERRING DR:___________________________________
PHONE NUMBER:__________________________________

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME:______________________ PHONE:________________
RELATIONSHIP TO PATIENT:_________________________

PRIMARY INSURANCE:_____________________
POLICY HOLDER NAME:___________________
POLICY NUMBER: ________________________
GROUP NUMBER:_________________________

INSURANCE ADDRESS:____________________
____
____

INS. PHONE:____________________________________

RELATIONSHIP TO PATIENT:________________
SUBSCRIBER DATE OF BIRTH________________

SECONDARY INSURANCE:___________________
POLICY HOLDER NAME__: __________________
POLICY NUMBER:__________________________
GROUP NUMBER:___________________________
INSURANCE ADDRESS:______________________
____
RELATIONSHIP TO PATIENT__________________
SUBSCRIBER DATE OF BIRTH: _______________
____

PATIENT RACE:
____ AMERICAN INDIAN ____ ALASKA NATIVE
____ ASIAN ____AFRICAN AMERICAN
_____ WHITE ____ HISPANIC _____ OTHER
_____ I DECLINE TO ANSWER

I HEREBY AUTHORIZE THE CORPORATION OF CHESAPEAKE & WASHINGTON HEART CARE, PC APPLY FOR INSURANCE BENEFITS ON MY BEHALF FOR SERVICES RENDERED BY THE OFFICE OF TERENCE BERTELE, MD AND HIS ASSOCIATES AND REQUEST THAT PAYMENTS ARE MADE DIRECTLY TO THE OFFICE MENTIONED ABOVE. I CERTIFY THAT THE INFORMATION I REPORTED WITH REGARD TO MY INSURANCE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

____
PATIENT SIGNATURE DATE

____
POLICY HOLDER SIGNATURE DATE

CHESAPEAKE & WASHINGTON HEART CARE, PC

INSURANCE AND BILLING PROCEDURES

1. **WE PARTICIPATE WITH THE FOLLOWING INSURANCE CARRIERS: MEDICARE, BLUE CROSS/BLUE SHIELD (NCA, MD AND CAPITAL CARE), MAMSI, UHC, MDIPA, AETNA, PHCS, NCPPO AND ALLIANCE. IF ANY INSURANCE COMPANY IS NOT LISTED, PLEASE DIRECT QUESTIONS TO OUR RECEPTIONIST.**
2. **IT IS THE RESPONSIBILITY OF THE PATIENT TO REVIEW HIS/HER INSURANCE COVERAGE TO KNOW IF A REFERRAL, PRECERTIFICATION OR A SECOND OPINION IS REQUIRED.**
3. **INSURANCE CLAIMS: WE WILL SUBMIT A CLAIM TO YOUR INSURANCE CARRIER, PROVIDED WE HAVE ALL THE NECESSARY INFORMATION. WE REQUIRE A COPY OF YOUR INSURANCE CARD. WE DO THIS AS A COURTESY TO OUR PATIENTS. IT IS UNDERSTOOD THAT IF THE CLAIM IS NOT PAID WITHIN SIXTY (60) DAYS, THE ACCOUNT BECOMES THE RESPONSIBILITY OF THE PATIENT.**
4. **PAYMENT AT TIME OF SERVICE: CO-PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE. PREVIOUS PAYMENT ARRANGEMENTS CAN BE MADE WITH OUR BILLING DEPARTMENT AT (301) 893-2861.**
5. **HMO/PPO: PATIENTS ARE RESONSIBLE FOR OBTAINING NECESSARY REFERRALS. ONLY IN EMERGENCIES WILL WE ATTEMPT TO OBTAIN A REFERRAL.**
6. **STATEMENTS/PAYMENT ARRANGEMENTS: YOU WILL RECEIVE A STATEMENT MONTHLY SHOWING CHARGES AND BALANCES. PLEASE RETURN PAYMENTS IN THE PRE-ADDRESSED ENVELOPE OR CONTACT OUR BILLING OFFICE TO ARRANGE A PAYMENT PLAN. AFTER 3 BILLING CYCLES WITHOUT PAYMENT, WE HAVE NO CHOICE BUT TO REFER BALANCES TO OUR COLLECTION DEPARTMENT.**
7. **MISSED APPOINTMENTS: WE REQUIRE 24 HOUR NOTICE OF APPOINTMENT CANCELLATION. FAILURE TO COMPLY WILL RESULT IN A $25.00 PHYSICIAN APPOINTMENT FEE & A $135.00 TESTING APPOINTMENT FEE.**

WE CARE ABOUT YOU & YOUR HEART.

I HAVE READ THE ABOVE BILLING POLICIES AND AGREE TO COMPLY.

______________________________	______________________________	_______
SIGNATURE	**PRINT NAME**	**DATE**

CHESAPEAKE & WASHINGTON HEART CARE, PC

PATIENT DISCLOSURE

LISTED BELOW ARE ANY PERSONS THAT MAY HAVE ACCESS TO MY PERSONAL HEALTH INFORMATION. I UNDERSTAND THAT AT ANY TIME, IT IS MY RIGHT TO REVOKE THIS AUTHORIZATION; HOWEVER THIS MUST BE IN WRITING.

NAME	RELATIONSHIP
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

____

PATIENT SIGNATURE AND DATE

DATE/RELEASED TO/CONTENTS/ INITIALS

____

____

____

CHESAPEAKE AND WASHINGTON HEART CARE, PC
HISTORY AND PHYSICIAL

PATIENT NAME:____________________________________ DOB:________________DATE ___/___/___

PLEASE COMPLETE ALL QUESTIONS BELOW. ENTER Y –YES, N – NO OR IF NOT APPLICABLE, PLEASE LIST N/A

PATIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN:_________________________ REFERRING:______________________

DIABETES	____	HEART DISEASE	___	ACUTE INFECTIONS	___
HYPERTENSION	____	ARTHRITIS/GOUT	___	VENEREAL DISEASE	___
CANCER	____	SEIZURE DISORDER	___	HEREDITARY DIS.	___
STROKE	____	BLEEDING EXCESS	___	TUBERCULOSIS	___
ASTHMA	____	RHEUMATIC FEVER	___	DEPRESSION	___
THRYROID DISEASE	____	LIVER DISEASE	___	KIDNEY DISEASE	___
CHRONIC BRONCHITIS/EMPHYSEMA	____				

PREVIOUS HOSPITALIZATIONS/SURGERIES AND APPROXIMATE DATE:
____
____
____

LIST CURRENT MEDICATIONS
____
____
____

DRUG ALLERGIES: ____

PATIENT SOCIAL HISTORY
MARITAL STATUS: _________
USE OF ALCOHOL: _________ **QUANTITY DAILY:**________
USE OF TOBACCO: _________ **PACKS/DAY** ___________ **QUIT DATE:**__________
RECREATIONAL DRUG USE: NEVER:____________ **TYPE/FREQUENCY:**_________

FAMILY MEDICAL HISTORY

	AGE	DISEASE	IF DECEASED, CAUSE/AGE OF DEATH
FATHER			
MOTHER			
SIBLINGS			
SPOUSE			
CHILDREN			

PATIENT NAME:___________________________________ **DATE:**________________________

SYSTEM REVIEW: CIRCLE Y OR N **PLEASE COMPLETE ALL ANSWERS**

CONSTITUTIONAL SYSTEMS

GOOD GENERAL HEALTH LATELY Y N
RECENT WEIGHT CHANGE Y N
FEVER Y N
FATIGUE Y N
HEADACHES Y N

EYES

DISEASE OR INJURY Y N
WEAR GLASSES/CONTACTS Y N
BLURRED OR DOUBLE VISION Y N
GLAUCOMA Y N

EARS/NOSE/MOUTH/ THROAT

HEARING LOSS OR RINGING Y N
CHRONIC SINUS PROBLEMS Y N
NOSE BLEEDS Y N
MOUTH SORES Y N
SWOLLEN GLANDS IN NECK Y N

CARDIOVASCULAR

HEART TROUBLE Y N
CHEST PAIN/ANGINA PECTORIS Y N
PALPITATIONS Y N
SHORTNESS OF BREATH W/WALKING Y N
SWELLING OF FEET,ANKLES,HANDS Y N

RESPIRATORY

CHRONIC OR FREQUENT COUGHS Y N
SPITTING UP BLOOD Y N
SHORTNESS OF BREATH Y N
ASTHMA/WHEEZING Y N

GASTROINTESTINAL

LOSS OF APPETITE Y N
CHANGE IN BOWEL MOVEMENTS Y N
NAUSEA OR VOMITING Y N
FREQUENT DIARRHEA/CONSTIPATION Y N
RECTAL BLEEDING/BLOOD IN STOOL Y N
ABDOMINAL PAIN Y N
PEPTIC ULCER Y N

GENITOURINARY

FREQUENT URINATION Y N
BURNING/PAINFUL URINATION Y N
BLOOD IN URINE Y N
KIDNEY STONES Y N
FEMALE-IRREGULAR PERIOD Y N

MUSCULOSKELETAL

JOINT PAIN Y N
WEAKNESS OF MUSCLES Y N
MUSCLE CRAMPS Y N
BACK PAIN Y N
COLD EXTREMITIES Y N

INTEGUMENTARY (SKIN, BREAST)

RASH/ITCHING Y N
CHANGE IN SKIN COLOR/NAILS Y N
VARICOSE VEINS Y N
BREAST PAIN/LUMPS/DISCHARGE Y N

NEUROLOGICAL

HEADACHES Y N
DIZZINESS Y N
CONVULSIONS Y N
TREMORS Y N
STROKE Y N
HEAD INJURY Y N

PSYCHIATRIC

MEMORY LOSS/CONFUSION Y N
NERVOUSNESS Y N
DEPRESSION Y N
INSOMNIA Y N

ENDOCRINE

GLANDULAR/HORMONE PROBLEM Y N
THYROID DISEASE Y N
DIABETES Y N
EXCESSIVE THIRST/URINATION Y N
HEAT/COLD INTOLERANCE Y N
SKIN BECOMING DRYER Y N

HEMATOLOGIC/LYMPHATIC

SLOW TO HEAL AFTER CUT Y N
BLEEDING/BRUISING TENDENCY Y N
ANEMIA Y N
PHLEBITIS Y N
PAST TRANSFUSION Y N
ENLARGED GLANDS Y N

ALLERGIC/IMMUNOLOGIC

HISTORY OF ADVERSE REACTION TO:
PENICILLIN/ANTIBIOTIC Y N
ASPIRIN/PAIN REMEDIES Y N
OTHER _________________________
____
____

REVIEWED BY DR: ____________________