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.

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. All medications that you are taking.
4. The attached forms filled out and signed. Please note: that if you do not have these forms filled out when you arrive you will be asked to reschedule.
5. Your referral from your primary care physician as well as any bloodwork and EKG results
6. Your copayment or coinsurance is due at the time of your visit.
7. You must arrive at least 15 minutes early so that we may process your paperwork. Please note: If you are late you will be asked to reschedule.
8. Patients that cancel or no show for their first visit will not be rescheduled.

If you have any questions, please feel free to contact our office at (301)645-5100.

We look forward to meeting you!

CHESAPEAKE AND WASHINGTON HEART CARE, PC

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH:___/___/_____ M / F

MARITAL STATUS:_____ SSN:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

PHONE:_____ /_____
HOME CELL

E-MAIL: _____

PREFERRED CONTACT: H___ C____ W___EMAIL____
CONSENT TO VOICE/TEXT MESSAGE Y___ N_____

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

NAME OF INSURANCE_____

POLICY NUMBER:_____

GROUP NUMBER:_____

INS. ADDRESS:_____

_____

INS. PHONE:_____

POLICY HOLDER:_____
RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE

POLICY NUMBER:_____
GROUP NUMBER:_____

INSURANCE ADDRESS:_____
_____:_____

POLICY NUMBER__:_____
RELATIONSHIP TO PATIENT:_____

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), UHC, OPTIMUM CHOICE, TRICARE, CIGNA, AETNA, PHCS AND US FAMILY. 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 RQUIRED AT THE TIME OF SERVICE. PREVIOUS PAYMENT ARRANGEMENTS CAN BE MADE WITH OUR BILLING DEPARTMENT AT (301) 645-5150.**
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-ADDRESD ENVELOPE OR CONTACT OUR BILLING OFFICE TO ARRANGE A PAYMENT PLAN. AFTER 2 BILLING CYCLES WITHOUT PAYMENT, WE HAVE NO CHOICE BUT TO REFER BALANCES TO OUR COLLECTION DEPARTMENT.**
7. **<u>MISSED APPOINTMENTS</u>: WE REQUIRE 24 HOUR NOTICE OF APPOINTMENT CANCELLATION. FAILURE TO COMPLY WILL RESULT IN A $30.00 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**

Notice of Privacy Practices Acknowledgment
Chesapeake and Washington Heart Care

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Chesapeake and Washington Heart Care Notice of Privacy Practices, 2013 Revision. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. By my signature below I acknowledge Chesapeake and Washington Heart Care PC is allowed to call me by name in the waiting area.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

The following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices have been made:

Date:_____ Date:_____ Date:_____

Attempt Description:_____

_____

Staff Name:_____

_____

Staff Signature

CHESAPEAKE AND WASHINGTON HEART CARE

NOTICE TO PATIENTS

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read this document carefully and sign the bottom of this form to acknowledge that you have received it.

A. The general consent for release of medical records that you sign authorizes Chesapeake and Washington Heart Care to disclose the information in your medical record for treatment payment and health care operations:
    1. For the purpose of providing treatment to you. Your information may be shared with e.g. employees and contractors of the provider, or with other health care providers who are treating you or consulting in your care.
    2. For the purpose of arranging payment of your care. Your information may be shared with your insurer of other third-party payer who is responsible for paying all or part of the cost for your care.
    3. For the purpose of health care operations. We may use and disclose information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may use information about you to remind you of an appointment for treatment of medical care.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under section (A) above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example if we receive a subpoena for the records or if public responsibility requires disclosure e.g. to protect public health. We will keep all disclosures of your medical records to the minimum necessary.

E. Your rights regarding health information about you.
    1. You have the right to inspect and copy your health information.
    2. If you feel that the health information we have about you is incomplete or inaccurate you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your request you have the right to ask that your statement be placed in the medical record.

3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosure made by us except for disclosures made for treatment, payment and health care operations.
4. You have the right to receive a paper copy of this notice.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to the Secretary of the U.S. Department of Health and Human Services or complain to us by talking to us, or writing to us with details. Please ask to speak to or contact our privacy complaints contact person(s) Pam Payne or Sherry Porter. We will not retaliate in any way against a patient for making a complaint.

G. We reserve the right to change our privacy practices and to make new policies effective for all protected health information that we maintain. If we should do so we will issue an updated "notice to patients" to all of our patients.

Please acknowledge receipt and review of this notice by signing below. For further information please call (301)645-5100.

Name of Patient: _____Date: _____

Signature of Patient or lawfully authorized representative: _____

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

_____

_____

_____

CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

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**

CONSITITUTIONAL 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
SWEELING 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: _____