Chesapeake & Washington Heart Care, PC

# Welcome

Thank you for choosing Cheasapeake & Washington Heart Care, P.C.!

We feel privileged that you have chosen our dedicated team of physicians to meet your cardiology needs.

Your appointment has been scheduled:

Date: _____

Time: _____ am / pm

Location: Waldorf / Leonardtown / Prince Frederick office

Enclosed are the forms necessary to complete your chart. Please complete these and return them to our office on the day of your appointment. We will also need you to bring all of your bottles for the medicines that you are currently taking, as well as, your insurance card(s), picture ID, referral (if needed by your insurance company) and any paperwork from your referring doctor.

If you find it necessary to cancel or reschedule your appointment, it is very important that you call us at least 48 hours prior to your appointment. Regrettably, if we do not receive this notice there will be a $100.00 missed appointment fee.

If you have any questions, please feel free to contact our office at:

Waldorf: (301) 645-5100
Leonardtown: (301) 475-3240
Prince Frederick: (410) 535-8262

We look forward to meeting you!!

Chesapeake Washington Heart Care, PC

Date: _____

# PATIENT INFORMATION - PART 1

**Patient Status** ◯ New ◯ Existing ◯ Former

## PATIENT INFORMATION

Full Name (First, Middle, Last) _____

Date of Birth _____ Gender at Birth ◯ Male ◯ Female

Address _____

_____

Home Phone _____ Cell Phone _____

Email _____

Military ◯ Yes ◯ No

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

## EMERGENCY CONTACT INFORMATION

Name _____

Phone Number _____

Relationship _____

## EMPLOYMENT INFORMATION

Occupation _____

Employer _____

Address _____

_____

Phone _____

Chesapeake & Washington Heart Care, PC

Patient Name: _____

Date: _____

# PATIENT INFORMATION - PART 2

## INSURANCE INFORMATION

*Primary Insurance*

Policy Holder _____

Policy # _____

Group # _____

Relationship to Patient _____

Address _____

_____

Phone _____

Fax _____

Email _____

*Secondary Inurance*

Policy Holder _____

Policy # _____

Group # _____

Relationship to Patient _____

Address _____

_____

Phone _____

Fax _____

Email _____

## DOCTOR'S INFORMATION

Primary Doctor _____

Phone _____

Referral Doctor _____

Phone _____

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. I also request that payments are made directly to the office mentioned above. I certify that the information I reported about my insurance is correct and I 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.

Name _____

Signature* _____

Date _____

** Signature of patient or lawfully authorized representative*

Chesapeake Washington Heart Care, PC

# INSURANCE AND BILLING PROCEDURES FOR ALL PATIENTS

1. **IF YOUR INSURANCE COMPANY IS NOT LISTED, PLEASE ASK OUR RECEPTIONIST TO VERIFY PARTICIPATION.**
   - **Participating:** Medicare, Carefirst Blue Cross/Blue Shield/BlueChoice/Anthem, United Health Care/MDIPA/Optimum Choice/Community Plan, Tricare/US Family/John Hopkins, AETNA, CIGNA, Humana Medicare, Maryland Medicaid, Medstar Choice, Priority Partners.
   - **Out of Network:** Medicare Advantage PPO
   - **Not Participating:** AETNA Better Health, Wellpoint, Amerigroup, Maryland Physicians Care, United Healthcare Medicare Advantage HMO, and Kaiser

**2. REFERRALS**: It is the responsibility of the patient to review his/her insurance coverage to know if a referral is required****

**3. INSURANCE CLAIMS**: We will submit a claim to your insurance company, provided we have all the necessary information. We require a copy of your insurance card. If you do NOT have a copy of your insurance card at the time of service-you will be registered as a 'self pay' and be responsible for the balance of your bill.

**4. PAYMENT DUE AT TIME OF SERVICE**: Co payments are required at the time of service and any coinsurances your insurance company reports you owe when we verify eligibility prior to your appointment.

**5. STATEMENTS**: You will receive a monthly statement showing charges and amounts that you owe/balance due. Please return payments in the pre-addressed envelope included.

**6. COLLECTIONS**: If no payments are received after two billing cycles, we will have no choice but to turn your account over lo a collection agency. If this occurs, there will be a 15% surcharge added to your balance to cover the cost of the collection agency fees.

**7. MISSED APPOINTMENTS**: We require 48 hour notice for appointment cancellations. Failure to comply, and/or 'No Shows' will result in a $100 fee for provider appointments and $200 for Cardiac Imaging/Nuclear Testing appointment. These fees must be paid before scheduling future appointments.

**8. RETURNING MEDICAL DEVICES**: Cardiac Monitoring Devices must be returned to the office when scheduled. Failure to return the Cardea Solo heart monitor will result in a $200 fee that must be paid before scheduling future appointments.

I have read the above Billing/Insurance Policies and agree to comply by evidence of my signature below.

Name _____

Signature* _____

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 _____

Signature* _____

Date _____

** Signature of patient or lawfully authorized representative*

| NAME | RELATIONSHIP |
|---|---|
| | |
| | |
| | |
| | |
| | |

### RELEASED INFORMATION

| Date | Content | Initials |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Chesapeake Washington Heart Care, PC

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 reccive 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.

Name _____

Signature _____

Date _____

** Signature of patient or lawfully authorized representative*

## RELEASED INFORMATION

*Office Use Only*

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

| | Date | Attempt Description | Staff Name and Signature |
|---|---|---|---|
| #1 | _____ | _____ | _____ |
| #2 | _____ | _____ | _____ |
| #3 | _____ | _____ | _____ |

Chesapeake Washington Heart Care, PC

## 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.

Chesapeake Washington Heart Care, PC

## NOTICE TO PATIENTS (continued)

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 invoice.

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 our patients.

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

Name _____

Signature* _____

Date _____

** Signature of patient or lawfully authorized representative*

Chesapeake Washington Heart Care, PC

Patient Name: _____

Date: _____

# HISTORY AND PHYSICAL

## PATIENT INFORMATION

Full Name (First, Middle, Last) _____

Date of Birth _____ Gender at Birth ◯ Male ◯ Female

## DOCTOR'S INFORMATION

Primary Doctor _____ Referral Doctor _____

## MEDICAL HISTORY ( Y - Yes N - No N/A - Not Applicable )

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | _____ | Heart Disease | _____ | Acute Infections | _____ |
| Hypertension | _____ | Arthritis / Gout | _____ | Venereal Disease | _____ |
| Cancer | _____ | Seizure Disorder | _____ | Hereditary Dis | _____ |
| Stroke | _____ | Bleeding Excess | _____ | Tuberculosis | _____ |
| Asthma | _____ | Rheumatic Fever | _____ | Depression | _____ |
| Thyroid Disease | _____ | Liver Disease | _____ | Kidney Disease | _____ |
| Chronic Bronchitis / Emphysema | _____ | | | | |

Cardiac Device Implant ◯ Yes ◯ No Type _____ Serial # _____

Drug Allergies _____

## SOCIAL HISTORY

Marital Status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

| | Yes | No | Type | Daily Quantity | Quit Date |
|---|---|---|---|---|---|
| **Alcohol** | ◯ | ◯ | _____ | _____ | _____ |
| **Tobacco** | ◯ | ◯ | _____ | _____ | _____ |
| **Vape** | ◯ | ◯ | _____ | _____ | _____ |
| **Recreational Drug** | ◯ | ◯ | _____ | _____ | _____ |
| **Other** | ◯ | ◯ | _____ | _____ | _____ |

Chesapeake Washington Heart Care, PC

Patient Name: _____

## HISTORY AND PHYSICAL (continued)

Date: _____

### MEDICATIONS

| | Name | Strength | Dosage Info |
|---|---|---|---|
| #1 | | | |
| #2 | | | |
| #3 | | | |
| #4 | | | |
| #5 | | | |

### TREATMENT HISTORY

| | Hospitalization | Surgery | Description | Approximate Date |
|---|---|---|---|---|
| #1 | ○ | ○ | | |
| #2 | ○ | ○ | | |
| #3 | ○ | ○ | | |
| #4 | ○ | ○ | | |
| #5 | ○ | ○ | | |

### FAMILY HISTORY

| | Age | Disease | If Deceased, Age & Cause |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |
| **Siblings** | | | |
| **Spouse** | | | |
| **Children** | | | |

Chesapeake Washington Heart Care, PC

Patient Name: _____

Date: _____

# SYSTEM REVIEW

Reviewed by Dr. _____

| *Constitutional Systems* | Yes | No |
|---|---|---|
| Good General Health | ○ | ○ |
| Recent Weight Change | ○ | ○ |
| Fever | ○ | ○ |
| Fatigue | ○ | ○ |
| Headaches | ○ | ○ |

| *Cardiovascular* | Yes | No |
|---|---|---|
| Heart Trouble | ○ | ○ |
| Chest Pain / Angina Pectoris | ○ | ○ |
| Palpitations | ○ | ○ |
| Shortness of Breath w/ Walking | ○ | ○ |
| Swelling of Feet, Ankles, Hands | ○ | ○ |

| *Neurological* | Yes | No |
|---|---|---|
| Headaches | ○ | ○ |
| Dizziness | ○ | ○ |
| Convulsions | ○ | ○ |
| Tremors | ○ | ○ |
| Stroke | ○ | ○ |
| Head Injury | ○ | ○ |

| *Endocrine* | Yes | No |
|---|---|---|
| Glandular / Hormone Problem | ○ | ○ |
| Thyroid Disease | ○ | ○ |
| Diabetes | ○ | ○ |
| Excessive Thirst / Urination | ○ | ○ |
| Heat / Cold Tolerance | ○ | ○ |
| Skin Becoming Dryer | ○ | ○ |

| *Hematologic / Lymphatic* | Yes | No |
|---|---|---|
| Slow To Heal After Cut | ○ | ○ |
| Bleeding / Bruising Tendency | ○ | ○ |
| Anemia | ○ | ○ |
| Phlebitis (Vein Inflammation) | ○ | ○ |
| Past Transfusion | ○ | ○ |
| Enlarged Glands | ○ | ○ |

| *Gastrointestinal* | Yes | No |
|---|---|---|
| Loss of Appetite | ○ | ○ |
| Change in Bowel Movements | ○ | ○ |
| Nausea or Vomiting | ○ | ○ |
| Frequent Diarrehea / Constipation | ○ | ○ |
| Rectal Bleeding / Blood in Stool | ○ | ○ |
| Abdominal Pain | ○ | ○ |
| Peptic Ulcer | ○ | ○ |

| *Musculoskeletal* | Yes | No |
|---|---|---|
| Joint Pain | ○ | ○ |
| Weakness of Muscles | ○ | ○ |
| Muscle Cramps | ○ | ○ |
| Back Pain | ○ | ○ |
| Cold Extremeties | ○ | ○ |

| *Ears / Nose / Throat / Mouth* | Yes | No |
|---|---|---|
| Hearing Loss or Ringing | ○ | ○ |
| Chronic Sinus Problems | ○ | ○ |
| Nose Bleeds | ○ | ○ |
| Mouth Sores | ○ | ○ |
| Swollen Glands in Neck | ○ | ○ |

| *Psychiatric* | Yes | No |
|---|---|---|
| Memory Loss / Confusion | ○ | ○ |
| Nervousness | ○ | ○ |
| Depression | ○ | ○ |
| Insomnia | ○ | ○ |

| *Eyes* | Yes | No |
|---|---|---|
| Disease or Injury | ○ | ○ |
| Wear Glasses / Contacts | ○ | ○ |
| Blurred or Double Vision | ○ | ○ |
| Glaucoma | ○ | ○ |

| *Respiratory* | Yes | No |
|---|---|---|
| Chronic or Frequent Coughs | ○ | ○ |
| Spitting Up Blood | ○ | ○ |
| Shortness of Breath | ○ | ○ |
| Asthma / Wheezing | ○ | ○ |

| *Genitourinary* | Yes | No |
|---|---|---|
| Frequent Urination | ○ | ○ |
| Burning / Painful Urination | ○ | ○ |
| Blood in Urine | ○ | ○ |
| Kidney Stones | ○ | ○ |
| Female - Irregular Period | ○ | ○ |

| *Integumentary (Skin / Breast)* | Yes | No |
|---|---|---|
| Rash / Itching | ○ | ○ |
| Change in Skin Color / Nails | ○ | ○ |
| Varicose Veins | ○ | ○ |
| Breast Pain / Lump / Discharge | ○ | ○ |

| *Allergic / Immunologic / Adverse Reaction* | Yes | No |
|---|---|---|
| Disease or Injury | ○ | ○ |
| Penicillin / Antibiotic | ○ | ○ |
| Aspirin / Pain Remedies | ○ | ○ |
| Other _____ | ○ | ○ |

Chesapeake Washington Heart Care, PC

## CRISP NOTIFICATION

We have chosen to participate in the Chesapeake Reginal Information Systems for our patients (CRISP), a reginal health information exchange service Maryland and Washington, DC. 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 (877) 952-7477 or completing & 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.

CRISP
Chesapeake Regional Information System for our Patients