C.A.I
A Cardiovascular & Arrhythmia Institute

Patient Registration Form

Patient: _____
SS #: _____ **Date of Birth:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone 1: ( )_____ **Cell Home Work**
Phone 2: ( )_____ **Cell Home Work**
Employer: _____

- **Email address to be able to access our online Patient Portal:**_____
- **If active in Portal, would you like to receive billing statements through email? Yes No**
- **Preferred Method of Contact (please note we will make phone calls for most communication but may use this method for other communication needs):** Letter Phone Email
- **Marital Status (please circle):** Single Married Widowed Divorced Separated
- **Race (please circle):** White Black or African American American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Undetermined (includes any race not listed)
- **Ethnicity (please circle):** Latino or Hispanic Not Hispanic or Latino Other
- **Gender (please circle:** Male Female
- **Language**: _____

Referred By :_____
Primary Care Physician: _____ **Phone #: ( )** _____
Emergency Contact: _____
Emergency Phone #: ( )_____

Insured Party Information (If other than yourself)

Name of Insured: _____ **Phone:**_____
Address of Insured: _____ **City/State/Zip:** _____
Employer of insured:_____
Date of Birth: _____ **SS#:**_____

Insurance Information

Primary Insurance: _____ **ID#:** _____ **Group:** _____
Address: _____ **City/State/Zip:** _____
Subscriber Name: _____ **Relationship to Patient:** _____
Secondary Insurance: _____ **ID#:**_____ **Group:**_____
Address:_____ **City/State/Zip:**_____

Authorization & Assignment

I hereby authorize Cardiovascular and Arrhythmia Institute, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. I hereby authorize direct payment of medical benefits to Cardiac Arrhythmia Institute, LLC, for services rendered. I understand that I am financially responsible for any balances not covered by my insurance. If this account is not paid promptly, and office deems it necessary to utilize a collection service, I agree to all reasonable collection fees and/or legal fees, plus the present balance of the delinquent account.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY (if other than patient): _____ DATE:_____

www.caiaz.com
10238 E Hampton Ave #501 Mesa, AZ 85209
Phone 480.889.1573 Fax 480.889.1574

Policy and Procedures of CAI

We would like to take this opportunity to welcome you to our office. The following document will outline our policies and procedures relating to our financial policy. Please take some time and read this document.

HEALTHCARE REQUIREMENTS: _____ **initials**

I authorize the above stated physician, his associates, assistants, and other qualified medical personnel of his/her choice to treat me and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for my medical condition. The Institute specializes in your complete Cardiovascular Care, including Electrophysiology and heart arrhythmias. We believe in providing you with the best possible care and working as a team with your family physician, internists, other cardiologists and/or any other specialists to help you with the latest care in healthy living.

PAYMENT AT THE TIME SERVICE IS RENDERED: _____ **initials**

Payment is required at the time services are rendered. We would appreciate your co-pays, deductibles, and/or patient non-insured portion at the time of the visits, if we participate with your insurance plan. This policy allows us to balance your account to zero when the insurance check arrives and saves you from receiving numerous monthly statements. We accept cash, personal checks, and MasterCard or Visa. For all returned checks an additional $25 fee will be assessed and incurred by the writer per check.

BILLLING PROCEDURES: _____ **initials**

As you visit our office requesting medical care, you undertake a personal obligation and responsibility for your account. All statements are mailed out monthly. We ask that you pay balances off monthly, (unless other arrangements have been made), and we regard any account over 90 days old as a matter of collection.

COLLECTION PROCESS: _____ **initials**

If any account does advance to collection and/ or litigation, the patient is financially responsible for all costs that might be incurred in collection said account, i.e. attorney fees, court costs, filing fees etc.

INSURANCE REFERRALS: _____ **initials**

For any contracted insurance plans that require a referral form, we must ask that the referral form be brought in with you at the time of the appointment. We will not await the referral by mail. If we do not have the referral form at the time of your appointment, your appointment will be rescheduled unless you are willing to pay in full that day.

Policy and Procedures of CAI- Continued

TREATMENT ESTIMATES: _____ **initials**

New patient visits take more time than return visits, therefore the charges are typically higher. You may feel free to discuss our fees with the billing office at any time. In addition, other testing may need to be performed; therefore the final charges may be more than what was originally estimated. Please know we are only given an estimate from your insurance company and this is subject to9 change.

ADDRESS AND INSURANCE CHANGES: _____ **initials**

Please keep us informed of address, telephone number, employment, or insurance changes.

INTEGRITY AGREEMENT: _____ **initials**

Both parties desire to have a method of resolving discomfort, misunderstanding, or disputes. If any of these previously mentioned occur, please bring it to our attention privately, quickly, and in a friendly manner. We agree to resolve these matters using the communication, mediation, and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement. (This in no way relinquishes your possibilities of seeking legal counsel.)

SPECIAL NEEDS:

We are here to help you. If you have special needs or circumstances that may require a payment plan, please feel free to discuss this with us as early as possible.

CANCELLATION OF APPOINTMENTS: _____ **initials**

We require a 24 hour cancellation notice of all scheduled appointments. Any appointments not cancelled within a 24 hour time frame will be subject to a cancellation fee.

Thank you for taking the time to read this policy and procedures statement. We hope that it answers any questions that you may have regarding the Institute's financial policies.

Patient's Declaration:
I have read and understand this policy statement. I understand that I am financially responsible for charges incurred and I authorize my insurance carrier to pay benefits to CAI Cardiac Arrhythmia Institute, LLC. All of my questions and concerns have been answered.

Signed_____ **Signed**_____
(Name) **(Guardian- if applicable)**

Date: _____

YOUR RIGHTS PURSUANT TO ARIZONA ADMINISTRATIVE CODE, TITLE 9, CHAPTER 10, ARTICLE 9 AND 10:

1. A patient is treated with dignity, respect, and consideration.
2. A patient is not subjected to:

    A. Abuse; neglect; exploitation; coercion; manipulation; sexual abuse or assault.
    B. Restraint or seclusion, except as allowed in R9-10-1012(B) if the center is authorized to provide behavioral health observation/stabilization services.
    C. Retaliation for submitting a complaint to the Arizona Department of Health Services or another entity; or
    D. Misappropriation of personal and private property by the center's personnel members, employees, volunteers, or students; and

3. A patient or the patient's representative has the right to:
    1. Consent to or refuse treatment, except in an emergency.
    2. Refuse or withdraw consent for treatment before treatment is initiated.
    3. Be informed of:
        i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure.
        ii. Policies and procedures on health care directives; and
        iii. The patient complaint process
    4. Consent to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to the center for identification and administrative purposes.
    5. Except as otherwise permitted by law, provide written consent to the release of information in the patient's medical record or financial records.
4. A patient has the following rights:

    A. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
    B. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
    C. To receive privacy in treatment and care for personal needs.

D. To review, upon written request, the patient's own medical record according to ARS 12-2293, 12-2294 and 12-2994.01.

E. To receive a referral to another health care institution if the center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.

F. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment.

G. To participate or refuse to participate in research or experimental treatment; and

H. To receive assistance from a family member, representative or other individual in understanding, protecting, or exercising the patient's rights.

5. These rights are also available as a separate document: Arizona Patient Rights and Responsibilities (PDF)

6. Fees for services are available upon request and can be provided by management.

7. State survey results available upon request with the Arizona Department of Health, phone number 602-364-3030.

I understand these rights and know I am encouraged to contact the Administrator should I have any questions or concerns.

Signed_____ **Signed**_____

(Name) **(Guardian- if applicable)**

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have received the Notice of Privacy Practices of Cardiac Arrhythmia Institute, LLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement. I also understand that CAI uses an electronic medication prescription program that retrieves your previous 2 years of prescribed medication. By signing below, I give consent to view these records.

OK to leave a voice mail for test results and general information? Yes / No

Please designate one person (name, relationship and phone number) other than yourself, who can receive information on you:

x_____ Phone Number _____.

Relationship_____ Date: _____

Signature of Patient or Patient Representative: _____

Print Patient or Patient Rep.'s Full Name:

_____

Brief Description of Patient Rep's Authority: _____

For Office Use ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of Notice of Privacy Practices of A Cardiovascular and Arrhythmia Institute, LLC. However, I could not obtain the written acknowledgment because: (please check a box below)

_____The individual refused to sign this acknowledgment

_____Communications barrier prohibited obtaining this written acknowledgment

_____An emergency situation prevented obtaining written acknowledgement

_____Other (please specify)

_____

C.A.I
A Cardiovascular & Arrhythmia Institute

Records Release

To: _____

_____

_____

_____

I hereby authorize: Cardiac Arrhythmia Institute, LLC

Copy or Summary of:

_____
_____
_____
_____
_____

Concerning my illness and/or treatment during the period from:

_____ to _____

Patient's Name: _____ DOB: _____

Signature: _____ Date:_____

Witness & Relationship of Witness:

_____

**** This authorization will expire in 12 months from the date of this signature****

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REGARDING PHOTOGRAPHY, VIDEO, AUDIO, AND ELECTRONICALLY RECORDED DATA POLICY

DEFINITIONS:

For the purposes of this policy, "photography or recording" refers to recording an individual's likeness (e.g., image or picture) or voice using photography (e.g. cameras or cellular telephones), audio recording (e.g, a tape or digital recorder), video recording (e.g., video cameras or cellular telephones), digital imaging (e.g., digital cameras or web cameras), or other technologies capable of capturing an image or audio data (e.g., Skype).

PURPOSE:

As a responsible health care provider, C.A.I. Cardiovascular & Arrhythmia Institute must take reasonable steps to protect its patients, visitors, employees and other staff members from unauthorized photography or recording. Due to the sensitive nature of patient information and to protect patient privacy, the policies and guidelines below apply to all photography, imaging, audio, video, or other electronic recording of patients, visitors, employees, or other persons present within a C.A.I. facility.

POLICY:

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) and regulations and guidelines promulgated thereunder, as well as to ensure that C.A.I. is able to effectively provide the highest quality treatment for its patients, the following policies apply to all photography or recording in C.A.I. facilities. These policies apply to patients, family members, visitors, other third parties, employees, and other C.A.I. staff members as set forth below:

I. Policy Regarding Photography or Recording by Patients, Family Members, Visitors, and other Third Parties

The following guidelines apply to all photography or recording by;

1. Patients, patients family members, visitors, and other third parties are prohibited from photographing or recording CAI personnel, equipment, or facilities.

2. Patients, family members, visitors, and other third parties are prohibited from taking photographs or recordings for insurance and/or legal purposes.

3. C.A.I. reserves the right to prohibit any photography or recording for any reason or for no reason.

Patient Signature _____ Date: _____

Advance Directive

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. You can write an advance directive in several ways:

- Use a form if provided by your doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized and copies should be given to your family and your doctor.

It is our policy to have each of our patient's Advance Directives reviewed and noted in the chart annually. Please choose from the list below and check what pertains to you.

- ☐ Discussed- No decision made
- ☐ You have a Living Will on file
- ☐ Do Not Resuscitate- please provide a copy for us to have on file
- ☐ Power of Attorney- please provide a copy for us to have on file
- ☐ Specific Advance Directive- please provide a copy for us to have on file

_____ _____
Patient signature Date

_____ _____
Witness signature (employee of C.A.I.) Date

C.A.I. A Cardiovascular & Arrhythmia Institute

CURRENT MEDICATION LIST

Date:_____

Name: _____ DOB: _____/_____/_____

Pharmacy Name: _____ Street Crossroads:_____

Prescription Medication	Strength	Times per day	Reason for Taking Medication

Over The Counter Medications, Vitamins & Supplements	Strength	Times per day	Reason for Taking

ALLERGIES TO MEDICATIONS

_____ Check here if NO Medication Allergies

Medication	What is your reaction to this medication?