MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.
MONTGOMERY, ALABAMA 36117

MCA Acct. #____________________________ Date______________________

Please Print

Name____
LAST FIRST MIDDLE PREFERRED/NICKNAME

Address____City__________________________State______Zip__________

Home Phone__________________ Cell Phone ________________ Email _____________________________

Drug Allergies____

Birthdate__________________Age_____Sex_____Race_____MartialStatus______S.S.#_____________________________

Patient/Parent's Employer _________________________________ ______________Bus. Phone__________________

Employer Address____City____________________State______Zip___________

Spouse______________________________________S.S.#_______________________________Birthdate________________

Spouse Employer____Bus. Phone__________________

Medical Physician____Referring Phys.______________________________

Next of Kin (Other than Spouse) _______________________Relationship_____________Phone #________________

Have you ever been treated by any of our doctors/hospital or office? ____

Pharmacy_________________________Address____________________________________Phone #___________________

PRIMARY INSURANCE

Name of Insurance Company____

Policy/Contract No.__________________________________Name of Insured____

Gp#_______________________________Gp Name/Employer____

OTHER INSURANCE

Name of Insurance Company____

Policy/Contract No.__________________________________Name of Insured____

Gp#_______________________________Gp Name/Employer____

I hereby authorize you to release and/or request any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioner, including test results which may include drug and/or alcohol, psychological conditions. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signed____Date__________________________________
Patient/Guardian

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

MONTGOMERY, ALABAMA 36117

Financial Policy

Thank you for choosing Montgomery Cardiovascular Associates, P.C. (MCA) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present their insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations:

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring **$100** at the initial appointment and may be billed for any additional balance. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments

MCA requires 24-hour notice of appointment cancellation. Physician appointments missed and are not previously canceled may be charged a fee of $25. Diagnostic appointments missed and are not previously canceled may be charged a fee of $50.

Returned Checks

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies
Patients requesting copies of medical records will be charged:
$5 retrieval fee
$1 per page for pages 1-25
$0.50 per page for pages > 25

A special handling fee of $10 will be charged if records must be delivered within 48 hours of the request.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.
Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand MCA's financial policy.

Signature ______________________________ *Date:* ____________________

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

MONTGOMERY, ALABAMA 36117

Patient Authorization for Use or Disclosure of Protected Health Information

With my consent, MCA may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to MCA's Notice of Privacy for a more complete description of such uses and disclosures. These notices are made available to you in each reception area, at each registration desk, and posted on the Montgomery Cardiovascular Associates, PC website at www.mcva.com .

I have the right to review the Notice of Privacy prior to signing this consent. MCA reserves the right to revise its Notice of Privacy at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to: MCA, 273 Winton M Blount Loop, Montgomery, AL 36117.

I understand that this authorization shall be in force and effect until I, the patient, request otherwise at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: MCA, 273 Winton M Blount Loop, Montgomery, AL 36117.

I understand that MCA may mail, call, or email to my home or other designated location any items that assist MCA in carrying out treatment, payment, and/or healthcare operations. (ie: appointment reminders, insurance items, information regarding my clinical care, lab results, patient statements, among others). I understand that MCA has the right to use my medical data in a de-identified manner for research purposes. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive treatment that I have requested for the purpose of disclosure to others.

I understand that I have a right to request a restriction on how MCA uses or discloses my Health information. However, MCA is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the MCA has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to MCA's use and disclosure of my Health information to carry out treatment, payment and healthcare operations.

____ ________________________________

Signature of Patient or Legal Representative | Date

____ ________________________________

(If signed by Legal Representative, state relationship and authority to do so | Signature of Witness

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

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HIPAA Permission for Release of Information

Patient Name: ___________________________________Date of birth: ________________

MCA account #: __________________________________

Due to HIPAA, we cannot leave medical information on your voicemail, send it by email or leave it with a member of your family. It is for that reason that we are having you give us authorization via this form.

A. If you would like to authorize to have information released to someone other than yourself, please complete the following:

Please list names of people authorized to receive your health information:

Name________________________Relationship________________

Name________________________Relationship________________

Name________________________Relationship________________

B. I authorize Montgomery Cardiovascular Associates and staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Montgomery Cardiovascular Associates whenever this information changes. Please list phone #, fax# or email address and check below all that applies.

Home Answering Machine #_____________ [ ] Yes [ ] No [ ] N/A

Work Telephone #___________________ [ ] Yes [ ] No [ ] N/A

Cell phone Voicemail ________________ [ ] Yes [ ] No [ ] N/A

Work Fax #_________________________ [ ] Yes [ ] No [ ] N/A

Home Fax #_________________________ [ ] Yes [ ] No [ ] N/A

Email Address________________________ [ ] Yes [ ] No [ ] N/A

[ ] I would prefer not to have messages left.

[ ] I give permission to electronically access prescription medication history from pharmacies that participate in E-Prescribing. Relationship _____________________

[ ] I do not give permission to electronically access prescription medication history from pharmacies that participate in E-Prescribing. Relationship _____________________

Signature________________________________ Date___________________

History and Physical

Name:______________________________ Date:______________________________

Age:____________ DOB:________________ Referring MD:______________________________

MCA Chart #:______________________________ Family MD:______________________________

PRESENT ILLNESS: (To be filled out by Doctor/Nurse)

PAST MEDICAL HISTORY: *Please ✓ those you have had or have now.*

_____High Blood Pressure
_____High Cholesterol
_____Diabetes Mellitus
_____Stroke
_____Arthritis/Gout
_____Peptic Ulcer Disease
_____Gallstones
_____Asthma
_____Hiatal Hernia
_____Cancer
_____Decrease blood supply to legs
_____Heart Attack

HOSPITALIZATION/SURGERY:

Year	Illness or Operation	Year	Illness or Operation

HAVE YOU HAD ANY OF THE FOLLOWING TEST, PROCEDURES, OR DEVICES? *Please ✓ if yes.*

_____Chest X-Ray When?__________ Where?______________________________
_____Treadmill When?__________ Where?______________________________
_____Echocardiogram When?__________ Where?______________________________
_____Monitors When?__________ Where?______________________________
_____EKG When?__________ Where?______________________________
_____Recent Blood Work When?__________ Where?______________________________
_____Heart Catheterization When?__________ Where?______________________________
_____Angioplasty (balloon procedure) When?__________ Where?______________________________
_____Pace Make When?__________ Where?______________________________
_____Defibrillator When?__________ Where?______________________________

ALLERGIES: Please list all medication and the reactions you had.

____
____
____

Please go to next page

Other allergies (foods, adhesive tape, x-ray contrast dye, etc.)

___

___

___

MEDICATIONS: List all medications you are currently taking.

Name of Drug	Dosage	Frequency
Example: Inderal	20 mg	4 times a day

FAMILY HISTORY

1. Describe your family's health (age, alive, deceased, major health problems):

Mother: ___

Father: ___

Brothers: ___

___

Sisters: ___

___

Children: ___

___

2. Immediate blood relatives that have had a heart attack (mother, father, brothers, sisters, children):

Relation	Age at onset	Age at death
___	___	___
___	___	___
___	___	___

3. Relatives that have had a stroke:

Relation	Age at onset	Age at death
___	___	___
___	___	___
___	___	___

SOCIAL HISTORY: Please fill out

Marital Status:___ Occupation:___

Smoker / Nonsmoker / Former Smoker ___packs per day ___no. of years year quit ___

Alcohol use ___oz. per week ___Caffeine

Daily Exercise:___

Please go to next page

Please ***CIRCLE*** only those problems you frequently experience or have been treated for in the past.

GENERAL:	Recent weight gain or loss	Fever or chills	Skin rashes	
HEAD/NECK:	Blurred Vision	Glasses	Glaucoma	Cataracts
	Vision Loss	Sinus Problems	Hearing Loss	Laser Surgery
	Dentures	Hoarseness		
RESPIRATORY:	Shortness of breath	Pneumonia	Bronchitis	Emphysema
	Asthma	Tuberculosis	Chronic Cough	Wheezing
	Coughing up Blood	Coughing up sputum	Blood Clots in Lungs	
CARDIOVASCULAR:	Chest Pain/Discomfort	Rheumatic Fever	Heart Murmur	Enlarged Heart
	Palpitations (fast, slow, irregular, fluttering, pounding heart beat)			
GASTROINTESTINAL:	Swallowing Problems	Poor Appetite	Indigestion/Heartburn	
	Stomach Ulcers	Liver Problems(hepatitis)	Gallstones	
	Yellowing of Skin	Blood in Bowel Movements	Dark black Bowel Movements	
	Diarrhea	Constipation	Change in bowel habits	
	Abdominal Pain			
GU:	Kidney Stones	Kidney Disease	Bladder Infections	Pain with urination
	Burning with urination	Difficulty holding urine	Difficulty starting or stopping stream	
	Prostate Problems			
PERIPHERAL VASCULAR:	Varicose Veins	Leg Cramps	Swelling in Ankles	
	Pain in calves with exercise		Blood clots in legs	
NEUROLOGICAL:	Blocked arteries in the neck	Weakness in the arms or legs		
	Numbness in the arms or legs		Seizures	Fainting
	Near Fainting	Severe Headaches	Memory Loss	Dizziness Tremors
MUSCULOSKELETAL:	Painful joints	Frequent Backaches		
HEMATOLOGIC:	Anemia	Bleeding Problems	Blood Transfusion	Easy Bruising
ENDOCRINE:	Diabetes	Thyroid Problems	Sensitive to heat and cold	
	Frequent urination	Frequent Thirst		
PSYCHOLOGICAL:	Depression	Anxiety	Not sleeping at night	

REPRODUCTIVE:

FEMALE: Last Menstrual Period:__________________________ Gone through Menopause:_______________

Age at Menopause:_________________ Taking hormone replacement:_____________

Taking birth control pills:_____________

MALE: Impotence:_____________

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

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www.mcva.com

EXERCISE ONLY FORM

PATIENT:		
MCA ACCOUNT NUMBER:		DATE:
Referring doctor:	Age:	Weight:

MEDICATIONS:

PRESENT COMPLAINT:

Do you have chest discomfort?	❑NO	❑YES	
Do you have a blood relative with heart disease?	❑NO	❑YES	
Do you Smoke?	❑NO	❑YES	Packs per day ___________
Do you have high cholesterol?	❑NO	❑YES	
Do you have Diabetes?	❑NO	❑YES	
Do you have a history of Heart Murmur or Rheumatic Fever?	❑NO	❑YES	
Do you have a history of Heart Attack or Heart Disease?	❑NO	❑YES	
Have you been told you have an abnormal EKG?	❑NO	❑YES	
Have you had heart fluttering or palpitations?	❑NO	❑YES	
Do you have Emphysema or Asthma?	❑NO	❑YES	
Do you have shortness of breath?	❑NO	❑YES	
Have you had a stroke?	❑NO	❑YES	
Have you had High or Low Blood Pressure?	❑NO	❑YES	
Do you have dizziness?	❑NO	❑YES	
Do you have an arm or leg that becomes weak or numb?	❑NO	❑YES	
Do you have breast implants?	❑NO	❑YES	

Physical Exam:____

Heart:____

Lungs:____

PLAN:
EVALUATION BY: