New Patient Referrals on par80 or Fast Track:

referrals@ohanacardiology.com
eFax 480-452-1486

'Ohana CARDIOLOGY

3420 S. Mercy Rd., Ste. 300 Gilbert, AZ 85297
480-955-0900 480-955-0800 *OhanaCardiology.com*

Michael D. Barry, DO., FACC
Interventional Cardiology
Michelle Gentsch, AG-ACNP
Adult Gerontology
Acute CareNurse Practitioner
Raul Rubio, FNP-C
Family Nurse Practitioner

1. PATIENT INFORMATION

PATIENT NAME: ____________ ____________ ____________
As it reads on insurance card *First* *Middle* *Last*

I GO BY: ____________ **BIRTH DATE:** ______ - ______ - ______
Month *Day* *Year*

SOCIAL SECURITY #: ____________ **LANGUAGE:** ☐English ☐Spanish ☐Other: ____________

ETHNICITY: ☐American ☐Hispanic ☐Latino ☐Not Hispanic ☐Unknown **GENDER:** ☐Male ☐Female

RACE: ☐Caucasian/White ☐Native American Indian/Alaskan ☐Asian ☐African American/Black ☐Hawaiian/Pacific Islander

MARITAL STATUS: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed ☐Life Partner ☐Other Relationship

PHYSICAL ADDRESS: ____________ ____________ ______ ______
☐*Permanent AZ Resident* *Address* *City* *State* *Zip*

SECONDARY ADDRESS: ____________ ____________ ______ ______
Address *City* *State* *Zip*

PREFERRED METHOD OF CONTACT

☐Work: ____________ Leave voice mail? ☐YES ☐NO ☐Home: ____________ Leave voice mail? ☐YES ☐NO

☐Cell: ____________ Leave voice mail? ☐YES ☐NO ☐Email ____________ ☐YES ☐NO

☐Patient Portal ☐YES ☐NO

TCPA Disclosure: *Due to enhancing our communications we are enabling patient appointment reminders and messaging via SMS mobile texting including voice telephone calls, reminder emails. This is an optional service to our patients and requires your consent in order to activate.* ***Please check one:*** ☐ YES ☐ NO

Disclosure to communicate, discuss and organize your care with the following person(s) listed below. I also understand I may revoke this authorization in writing at any time:

EMERGENCY CONTACT FULL NAME: ____________ **RELATIONSHIP:** ____________

EMERGENCY CONTACT PH: ____________

FULL NAME: ____________ **RELATIONSHIP:** ____________ **PH:** ____________

FULL NAME: ____________ **RELATIONSHIP:** ____________ **PH:** ____________

COORDINATION OF CARE:

PRIMARY CARE PHYSICIAN: *please print* ____________ **PH:** ____________

REFERRING PHYSICIAN: *please print* ____________ **PH:** ____________

OTHER PHYSICIANS: *please print* ____________ **PH:** ____________
Podiatrist, Nephrologist, Endocrinologist, Pain Management, etc.

2. INSURANCE INFORMATION *Please note it's important to bring all insurance card(s) with you to every visit and provide to our staff.*

PRIMARY INSURANCE: ____________ **EFFECTIVE DATE:** ____________

POLICY ID #: ____________ **GROUP #:** ____________

POLICY HOLDER FULL NAME: *please print* ____________ **DOB:** ____________

SECONDARY INSURANCE: ____________ **EFFECTIVE DATE:** ____________

POLICY ID #: ____________ **GROUP #:** ____________

POLICY HOLDER FULL NAME: *please print* ____________ **DOB:** ____________

INSURANCE DISCLOSURE/ACKNOWLEDGMENT/AGREEMENT: I request payment of authorized Medicare and health insurance benefits for any services furnished to me or my dependents by or in 'Ohana Cardiology. I authorize any holder of medical or other information about me or my dependents to release to Medicare and/or health insurance agents any information needed to determine these benefits or benefits for related services. I hereby authorize 'Ohana Cardiology to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for recertification, authorization, or referral to other medical provider(s). I furthermore authorize payment of medical benefits directly to my physician for services rendered, Patient agrees to be financially responsible for any balances owed should insurance determine the services not medically necessary or non-covered by insurance plan. Your signature below forms a binding agreement between 'Ohana Cardiology (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party.

PATIENT FULL NAME: *please print* ____________

SIGNATURE: *please print* ____________ **DATE:** ____________

3. PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

Do you currently have or recently have had any of the following symptoms?

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Chest Discomfort
- ☐ Fluttering Feeling in Chest
- ☐ Skipped Heart Beats/Palpitations
- ☐ Swelling in Ankle/Feet
- ☐ Varicose Veins

INTEGUMENTARY
- ☐ Skin Rash
- ☐ Skin Ulcers
- ☐ Non-Healing-Wounds

NEUROLOGICAL
- ☐ Headaches/Migraines
- ☐ Memory Loss
- ☐ Speech Problems
- ☐ Dizziness/Fainting Spells
- ☐ Neuro Stroke

GASTROINTESTINAL
- ☐ Loss of Bladder Control
- ☐ Blood In Urine

HEMATOLOGY/HEPATIC
- ☐ Breast Masses/Lumps
- ☐ Enlarged Lymph Nodes
- ☐ Unexplained Bruising

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Leg Pain

EAR/NOSE/MOUTH/THROAT
- ☐ Difficulty Swallowing
- ☐ Dry/Hoarse Throat

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ High/Unusual Stress
- ☐ Eating Disorder

CONSTITUTIONAL
- ☐ Significant Weight Loss
- ☐ Significant Weight Gain
- ☐ Night Sweats
- ☐ Unexplained Fever

ENDOCRINE
- ☐ Thyroid Problem

EYES
- ☐ Blurred/Double Vision
- ☐ Cataracts
- ☐ Glaucoma

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ History of Tuberculosis
- ☐ Valley Fever
- ☐ Lung Disease

4. PATIENT FAMILY HISTORY AND RISK FACTORS

Please check all medical issues in your immediate family, biological family such as parents, grandparents, brothers and sisters.

☐ Heart Disease Who? Please list____________________

☐ High Blood Pressure Who? Please list____________________

☐ Bleeding Disorders Who? Please list____________________

☐ Renal/Kidney Failure Who? Please list____________________

☐ Lung Disease Who? Please list____________________

☐ Heart Murmur Who? Please list____________________

☐ Stroke Who? Please list____________________

☐ Diabetes Who? Please list____________________

☐ Valley Fever/TB Who? Please list____________________

☐ Cancer Who and what type(s)? ____________________

Are you currently enrolled in Pain Management? ☐ Yes ☐ No

Provider Name ____________________ Clinic Name ____________________

Clinic Phone ____________________ Clinic Address ____________________

☐ I have filled out my personal medical history including past family medical history to the best of my abilities

PATIENT SIGNATURE: *please sign* ____________________ **DATE:** ____________

5. PATIENT MEDICAL HISTORY AND RISK FACTORS

Please check all medical issues you have had in the past

MEDICAL ISSUES

- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Renal Kidney Failure
- ☐ Lung Disease
- ☐ Intestinal Disease
- ☐ Thyroid Disease
- ☐ Asthma/Emphysema
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Diabetes
- ☐ Anesthesia Problems
- ☐ Valley Fever/TB
- ☐ Drug Abuse
- ☐ Cancer *please list type:* ______________________________

WOMEN'S CARDIOVASCULAR HEALTH

- ☐ Have you had a total hysterectomy?
- ☐ Do you take Birth Control Pills?
- ☐ Have you gone through Menopause?
- ☐ Are you taking hormone replacements?
- ☐ Pain or discomfort in the chest, in left arm, or back
- ☐ A faster heartbeat
- ☐ Irregular heartbeats (skipped beats, flip-flop feeling in your chest)
- ☐ Shortness of breath
- ☐ Nausea and/or vomiting
- ☐ Sudden sweating or sweating when there is no real cause (cold, clammy feeling)
- ☐ Light-headedness or Dizziness
- ☐ Neck, jaw, shoulder, upper-back or abdominal discomfort
- ☐ Unusual Fatigue
- ☐ Extreme weakness
- ☐ Indigestion

SOCIAL HABITS

Do you or have you?

- ☐ Use Tobacco How often? ______________________________ When did you quit? ______________________________
- ☐ Drink Alcohol How often? ______________________________ When did you quit? ______________________________
- ☐ Drink Caffeine How often? ______________________________ when did you quit? ______________________________
- ☐ Take Illicit Drugs? How often? ______________________________ When did you quit? ______________________________

List any problems with mobility or self-care: ____

____

____

6. SURGICAL PROCEDURES AND OPERATIONS HISTORY

PROCEDURES & SURGERIES *List type of procedure and mm/yy performed:*

- ☐ Heart Surgery
- ☐ Vascular Surgery
- ☐ Cardiovascular Procedures/Interventions
- ☐ Other Surgeries

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

Procedure ______________________________ Date *(mm/yy)* ______________

DEVICE IMPLANT INFORMATION *Include Type, Serial # and Implant Date*

Type: ______________________________ Serial Number ______________ Implant Date: ______________

Type: ______________________________ Serial Number ______________ Implant Date: ______________

Type: ______________________________ Serial Number ______________ Implant Date: ______________

PATIENT SIGNATURE: *please sign* ______________________________________ **DATE:** ______________

7. CURRENT MEDICATION LIST *Please provide a list to our staff during each office visit.*

I [______________________________], understand Dr. Michael Barry DO., FACC and Medical Providers of ‘Ohana Cardiology rely on medication information I provide to them for my care, and any medication misinformation can result in hospitalization and/or death. By signing, I confirm the medication information I am providing here is accurate and complete.

Please list any allergies/intolerance to medications and reaction(s): ______________________________

____

Please list any other Allergies and reaction(s); *food, adhesive tape, x-ray contrast dye, latex etc.* ______________________________

____

PHARMACY: *please print* ______________________________ **PH:** ______________

PHARMACY ADDRESS/CROSS-STREETS: ______________________________

RX CARD POLICY INFORMATION:

BIN #: ______________ **GROUP #:** ______________ **PCN #:** ______________ **PH #:** ______________

	MEDICATION NAME	DOSAGE (MG)	# TIMES PER DAY TAKEN	START DATE	PRESCRIBING PHYSICIAN
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

PATIENT SIGNATURE: *please sign* ______________________________ **DOB:** ______________ **DATE:** ______________

8. NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES [HIPPA] AND CONSENT

Our notice of privacy practices provides information on how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you have the right to obtain our current notice by contacting our practice. You have the right to request that we restrict how protected healthcare information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to the restriction, but if restriction is agreed upon it will be an honored agreement.

THE PATIENT UNDERSTANDS THE FOLLOWING: Protected Health Information may be disclosed or used for treatment, payment or health care operations. The Practice has Notice Of Privacy Practices and the patient has an opportunity to review this notice. The Practice refuses the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of his/her protected health care information, but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing, at any time, and all future disclosures will then cease. The Practice may condition receipt of treatment upon execution of this consent.

9. PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND REQUEST MEDICAL RECORDS RELEASE

HIPAA laws allow the Clinic to include in a "medical record request" records that the providers at the Clinic used to make decisions about patients. These can include such additional items as medical records brought/sent to the Clinic by a patient from other healthcare providers, billing records, and/or registration papers. Many patients have found that they do not need all of these records as they have kept a copy of records provided to the Clinic from other healthcare providers, and have received insurance billing records directly from their specific insurance company. Please Note we require a signed Authorization to release Medical Records to be updated every 90-days.

10. MEDICAL RECORDS RELEASE ACKNOWLEDGMENT

I understand HIPPA laws allow a processing time up to 30 days to process medical records requests. However, our clinic strives to complete this process within 3-5 business days from receipt of our medical release form. ***Disclaimer (should read):*** *I understand I may revoke this authorization, except to the extent that action has already been taken, in writing at anytime by sending written revocation of authorization to the releasing provider. I understand once information is used or disclosed based on this authorization, it may be re-disclosed by the recipient and at such time may no longer be protected by Federal privacy laws or regulations. I hereby consent and authorize you to release copies of my personal health information including current and previous medical records from other practices and practitioners, hospitals and/or clinics, which are part of my medical records. I agree that a copy or fax of this release shall be valid as the original release.*

11. FINANCIAL POLICY AND PATIENT'S RESPONSIBILITY ACKNOWLEDGMENT

We will bill your insurance company. We ask for your cooperation at every appointment, you present your Driver's License and/or Government Issued Photo ID., and all current insurance card(s). If accurate insurance information is not furnished to our office, this impacts delay in timely filing claim submission and therefore, you will be held responsible for the full amount of the charges. Furthermore, you have been requested to authorize payment of medical benefits directly to your physician for services rendered, and have agreed to be financially responsible for any balances owed should your insurance determine the services are not medically necessary or non-covered by the insurance plan.

12. RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS ACKNOWLEDGMENT

I request payment under the medical insurance program be furnished to my provider(s) under 'Ohana Cardiology, on any bills or services furnished to me during the effective periods of this authorization. I further authorized 'Ohana Cardiology, to release to the Social Security Administration and/or to its Intermediaries or carriers any information needed for my claims or any related Insurance/Medicare claims.

UNDERSTANDING YOUR INSURANCE POLICY. Resources are available through your insurance plan to assist you in understanding your insurance coverage, in addition to verification. 'Ohana Cardiology and Providers are an active participating provider for covered and non-covered benefits, including authorization requirements, cost share information such as deductibles, co-insurance, and copays in addition to PCP [primary care provider] referral requirements. Should your plan require an authorization referral for treatment from the carrier prior to receiving services, we reserve the right to reschedule your appointment should your referral not be obtained prior to your appointment. Understanding your policy requirements will assist us in preventing canceling and/or rescheduling any appointments. Any non-covered services are the patient's financial responsibility.

INSURED: All co-pays, deductibles, and co-insurances must be paid before services are rendered and will be collected at check-in of every appointment. If unable to pay at the time of your check-in appointment, your appointment may be rescheduled.

NON-INSURED: 'Ohana Cardiology requires full payment(s) at time of service, unless prior arrangements have been approved through our Billing Manager.

PATIENT BALANCES: Balances remaining after insurance carriers payments have been satisfied must be paid within 30 days of receiving your patient statements, unless prior arrangements have been approved through our Billing Manager.

MEDICAL FORMS REQUEST: Fee of $30.00 will be collected to process medical forms such as FMLA, FAA clearance, Disability, etc., for processing and completion. This service is not paid by your insurance carrier. An appointment may or may not be required to fill out paperwork in addition to the fee.

CANCELLATION POLICY FOR APPOINTMENTS: Although we realize you might need to reschedule/cancel an appointment, we require a 24-hour advance notification of cancellation to allow us an opportunity to offer your appointment time to another patient in need. Should you fail to notify us, variant fees are subject to apply depending on your appointments scheduled with us; $50.00 appointment fee, $275.00 Nuclear Stress Test and/or Angiograms, $100.00 Ultrasounds. Please note, this charge is not covered by your insurance and is the patients responsibility.

NON-SUFFICIENT FUNDS/RETURNED CHECKS FEES: We will apply a $40.00 NSF bank charge/fee for any returned checks. The fees will be added to your account balance and will be your responsibility. In addition, the financial institution may also charge additional fees to you directly.

FINANCIAL POLICY AND PATIENT'S RESPONSIBILITY ACKNOWLEDGMENT: I certify I have read, reviewed, and understand, the above noted policies, disclosures and acknowledgments for release of medical records, patient rights and responsibilities, assignment of benefits. I further understand, regardless of my insurance claim status, or absence of my insurance coverage, I am ultimately responsible for all balances on my account for all services rendered. I understand payments can be made by cash, check or credit card, and understand that should my account be referred to a collection agency or attorney, I will be responsible for all costs in collection of my account, including attorney fees and can be subject to interest and penalty fees on balances due.

By signing this form you agree to consent to our use and disclosure of protected healthcare information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 [HIPAA].

I [_________________________________], acknowledge I have received and reviewed the Notice of Privacy Practices for Dr. Michael Barry DO., FACC and Medical Providers of 'Ohana Cardiology. I understand I may waive to sign this acknowledgment.

Patient Full Name: *please print* ____

Patient Signature: ____ Date: ____________________

YOUR INFORMATION • YOUR RIGHTS • OUR RESPONSIBILITIES

OUR USES AND DISCLOSURES

We may use your information as we:

- Treat you.
- Coordinate care.
  - We can use your healthcare information and share with other professionals who are treating you.
  - We can use your healthcare information to manage your treatment and services.
- Bill for your services.
  - We can use and share your healthcare information to bill and receive payment for services rendered by health plans and other entities.
- Addressing workers' compensation, law enforcement and other government request.
  - We can use and share your healthcare information to process workers' compensation claims.
  - We can use and share your healthcare information for law enforcement with health oversight agencies for such activities authorized by law.
- Comply with the Law, responding to legal actions and/or lawsuits.
  - We can use and share your healthcare information if State and/or Federal law requires us to do so, including the Department of Health and Human Services, in compliance with the law.
  - We can use and share your healthcare information in response to a court or administrative order, and/or a court ordered subpoena.
- Assist with public health and safety issues.
  - We can use and share your healthcare information in such instances as disease prevention, assisting with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, domestic violence. Preventing a serious threat to anyone's health and/or safety.
- Research.
  - We can use or share your healthcare information for the purposes of health research.

For more information visit: https://www.hhs.gov/hipaa

YOUR CHOICES

You can chose the way we use and share your information as we:

- Inform family and friends about your condition.
  - Share information with with your family, friends or others involved in your care.
- Include you in a hospital directory.
  - Including your information in a hospital directory.
  - Share your information in a disaster relief information.
- Market our services and sell your information.
  - Marketing purposes.
  - Sale of your information.
- Raise funds.
  - Community and other fundraising efforts.

YOUR RIGHTS

You have the right to:

- Obtain a copy of both your paper and/or electronic medical records.
  - You may request to see or obtain a paper or electronic copy of your medical records and other healthcare information we have on you. Your medical records signed release will be honored, usually within 5-7 business days, although by law, we reserve the right to take up to 30 days and can charge reasonable cost-based fees.
- Correct both your paper and/or electronic medical records.
  - You may request corrections of your healthcare information which you may feel is inaccurate and/or incomplete. Ask us how.
- Request confidential communication.
  - You may request our practice communicate with you in a certain form of preference of communication(s). Such requests are subject to the TCPA disclosure, within reasonable request.
- Request our practice to limit the information we share.
  - You may request our practice not use or share certain healthcare information for treatment, payment or our operations. We are not required to honor your request and such may be declined if we feel it would impact your care.
  - Should you pay for service or healthcare items out of pocket in full, you may request we not share that information for the purpose of payment or our operations with your healthcare carrier, unless we are required to do so under law.
- Request a list of those whom we've shared your information with.
  - You may request an accounting list of those whom we've disclosed your healthcare information to for six years prior to the date of your request. We will include all disclosures including with exception to treatment, payment, and healthcare operations and other certain disclosures, such as any you may have asked us to make. We provide one accounting list per year for free, but will charge a reasonable cost-based fee should one be requested within that 12-month period.
- Request a copy of our Privacy Practice Notice.
  - You may request a copy of this notice at any time, even if you've agreed to receive this notice electronically. We will promptly provide a paper copy upon your request.
- Choose someone to act on your behalf.
  - If you have given someone medical power of attorney and/or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will ensure that person has authority to act on your behalf before we take any action.
- File a claim if you believe your privacy acts have been violated.
  - You can file a complaint if you feel we have violated your rights by contacting us at: **480-955-0900** and should you choose, you may also file a formal complaint through: **US Department of Health and Human Services office by visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.** We, as a practice, will not retaliate against you for filing.

understanding/consumers/noticepp.html.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected healthcare information.
- We will notify you promptly, should a breach occur which may have compromised the privacy and security of your information.
- We must follow the duties and privacy practices described in this notice and furnish a copy to you.
- We will not use or share your information other than described here, unless provided in writing to disclose. Should you choose to disclose, you may change your mind at anytime, and you would be required to provide in writing the changes needed.

For more information we encourage you to visit: www.hhs.gov/ocr/privacy/hippa/

Changes to the Terms Of This Notice: **effective: 03/2022 - applies to 'Ohana Cardiology**
Are subject to change and all changes will apply to all information we have about you. The new notice will be available to you upon your request both in our office and available for download on our website.