



Dear Patient,

**RE: Important Checklist To Complete Before Your Appointment**

On behalf of your physician, welcome to Tri-City Cardiology. Our goal is to provide you with very good care and service. This packet is an important part of our new patient registration process. Gathering this information will help us provide you with very good care and ensure accurate billing for the services we provide.

The following is a checklist of items included in this packet that need to be read and completed to the best of your abilities.

**Please bring all completed forms with you at the time of your appointment.**

**READ**

- Form 1**, Read the IMPORTANT NOTICE TO OUR PATIENTS regarding arrival time. We expect you to arrive twenty (20) minutes prior to your appointment in order to complete your registration.
- Form 2**, Read the IMPORTANT MESSAGE ABOUT CALLING TRI-CITY CARDIOLOGY
- Form 3**, Read the IMPORTANT MESSAGE ABOUT REGISTRATION
- Form 11**, Read the IMPORTANT MESSAGE ABOUT MANAGING YOUR MEDICATIONS, PRESCRIPTIONS AND REFILL REQUESTS

**COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT**

- Form 4**, Read and complete the PATIENT INFORMATION FORM (front & back)
- Form 5**, Read and sign the IMPORTANT MESSAGE ABOUT OUR FINANCIAL POLICY AND BILLING (front and back)
- Form 7**, Read, complete, and sign AUTHORITY TO RELEASE MEDICAL INFORMATION FORM
- Form 8**, Read, complete, and sign PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE (back & front)
- Form 9**, Read, complete, and sign the SLEEP EVALUATION FORM
- Form 10**, Read and complete the PERIPHERAL VASCULAR HEALTH SCREENING QUESTIONNAIRE

**BRING TO YOUR APPOINTMENT**

- Bring all of your prescription medication bottles with you
- Bring all of your current insurance cards
- Hospital discharge instructions
- All completed forms
- Bring credit card, checkbook or cash for payment at time of service

If you have any questions regarding your upcoming appointment please call 480-835-6100, Option 2. We are excited about the opportunity to provide you with very good care and service. If you have any other questions or concerns, you may contact Mykl Garrett, CEO, at 480-993-1060. Thank you.

**Form 1, Important Notice to Our Patients**  
Tri-City Cardiology Consultants, P.C.

**Important Notice to Our Patients**

In order to run our office schedule on time we must have patients arrive at least 20 minutes before their appointment time. Before every appointment our patients must be registered and clinical data verified.

**We need help from our patients to run an efficient office schedule.** We strive to provide very good care and service. Reducing patient waiting time and running our physician office schedules on time is very important to us and our patients. If we all work together we can run a more efficient office schedule.

We have been working hard to understand our waiting times. Studies have shown us two things: first that a speedy registration takes at least 10 minutes and the medical assistant requires up to 10 minutes. Second that the top three reasons causing our office schedules to run behind are:

- Patients not arriving 20 minutes prior to appointments (70%)
- Physician emergencies interrupting clinics (20%)
- Physicians taking more time with an ill patient (10%)

Please help us by arriving at least 20 minutes before your appointment time. We will work hard to provide a speedy registration and keep your waiting times to a minimum.



## Form 2, Important Message about Calling Tri-City Cardiology

Dear Patient,

- Our goal is to provide you with very good care and service. We know helpfulness on the phone is important to you. Here are some helpful tips to reduce your wait time on the phone. For your convenience you can now reach us through our website at [www.tricitycardiology.com](http://www.tricitycardiology.com) and leave a message under the tab CONTACT US. When you call 480-835-6100 your call will be answered by an automated attendant, at which time you will be offered the following options:

You may reduce your wait time on the phone in several ways:

- Option 1: **Hospitals and Referring Physicians.**
- Option 2: **Scheduling** office appointments. If you are calling to schedule an appointment or change an appointment.
  - For questions regarding today's visit, press 1
  - To schedule or reschedule an appointment, press 2 now or you may contact our scheduling department through our website: at [www.tricitycardiology.com](http://www.tricitycardiology.com) and click the "contact scheduler" link.
- Option 3: **Secretary or Physician Needs.**
  - This will direct you to our operator to facilitate your request.
- Option 4: **For all other calls.**
  - For office hours, location and fax numbers, press 1
  - For Medical Records, press 2
  - For Billing, press 3
  - For medication refill questions, press 4 now to leave a message
  - To leave a non-urgent voicemail, press 5
  - To return to the main menu, press 6
  - For all other calls, please remain on the line

### IMPORTANT TIPS:

- **Callback Option:** You will be offered the callback option after one (1) minute of hold time. Please listen carefully for the following statement. "If you wish for us to hold your place in line and call you back when it is your turn, please press 1. You simply press 1 after this option and the system will verify your callback number. If this is the correct number you would like to be called back at, press 1. If you wish to be called back at a different phone number, you may press 2 and follow the prompts. The system will ask you to enter the different phone number you would like the system to call followed by #. It will also ask you if you have an extension number. To bypass this option, press 2. The system will then ask you to record a message. At this time you must record a brief message followed by # in order to complete the callback request. If you fail to leave a message, the system will not return your call.
- **High Volume Call Days:** Please note our high volume call periods are typically all day Monday as well as Tuesday through Friday from 8:30 A.M. to 10 A.M. and 12:30 P.M. to 1:30 P.M. During high volume call periods your wait may be longer. Remember, if you are unable to wait, press (1) after the voice prompt that asks you if you want an operator to call you back when it's your turn in line. You will not lose your place in line if you use this option.
- **Non-Urgent Voicemail.** If you would like to leave a Non-Urgent message for the office staff or physician, please use option 4 and then press 5. We will return your call by the end of the next business day.
- **Website:** You may also reach us through our website at [www.tricitycardiology.com](http://www.tricitycardiology.com) and leave a message under the tab CONTACT US.



## Form 3, Important Message about your Visit

Dear Patient,

Our goal is to provide you with very good care and service. It is very important that you arrive on time. The following describes key steps regarding your visit:

**Arrival Time:** We are expecting you to arrive 20 minutes prior to your appointment time to begin your registration process.

**Late Arrival Policy:** If you arrive more than fifteen (15) minutes late, you may be asked to reschedule your appointment (s).

**Registration:** Our registration process includes updating your demographic, insurance, and health information. We always want to provide you with a speedy registration process. However, sometimes we may need up to twenty (20) minutes to complete your registration effectively.

The final part of your registration process will be to review your financial obligations to ensure the accuracy of your bill. We will ask you to pay your co-payments, deductibles, and any outstanding balances due. During your wait time before going to the exam room, you may be asked to fill out additional paperwork to enhance the quality of your care.

**Patient Rooming:** The rooming process begins when the medical assistant escorts you from the waiting room to an exam room just prior to your appointment time.

**Appointment Time:** Your appointment time is the time you are to begin your exam or procedure. Your physician will be using a computer in the exam room to access and update your medical information as part of an electronic medical record process.

**Checkout Process:** After you have completed your appointment, you will be directed to a scheduler. In most cases, your visit will be completed at that time and you can leave the office.

Thank you and we are excited about the opportunity to provide you with very good care and service. If you have any questions or concerns, please contact Mykl Garrett, CEO at 480-993-1060.



**Activity Level:** which of the following best describes your level of physical activity both in your daily life and your leisure time

- Exercise strenuously on a regular basis
- Exercise moderately on a regular basis
- Exercise on an occasional basis

- Do not regularly exercise, but have an active lifestyle
- Have difficulty accomplishing light chores of daily living
- Require assistance to accomplish self-care

Have You Ever Had Any of the Following	Yes	No	Date or Year	Place (Hospital or City)	Complications/Problems
Exam by a Cardiologist (Heart Doctor)	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Catheterization or Angiogram	<input type="checkbox"/>	<input type="checkbox"/>			
Coronary Angioplasty (PTCA/Balloon/Stents)	<input type="checkbox"/>	<input type="checkbox"/>			
Exercise Stress Test (Treadmill)	<input type="checkbox"/>	<input type="checkbox"/>			
Echocardiogram (Ultrasound of the Heart)	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			
Open Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Nuclear Study	<input type="checkbox"/>	<input type="checkbox"/>			
Holter/Event	<input type="checkbox"/>	<input type="checkbox"/>			

Previous Operations/Procedures	Year	Surgeon	Place (Hospital or City)	Complications/Problems

Reasons for other Hospitalizations (non-Surgical Admissions)	Year	Physician	Complications/Problems

Please List Any Other Medical Illnesses, Any Other History of Cancer or Chronic Conditions	How Long Have You Had This

**Family History**

- Heart Attack
- Sudden Death
- Stroke
- Aneurysm
- Diabetes
- Cancer
- High Blood Pressure
- High Cholesterol
- Heart Failure

Relation	Age	Age at Death	Heart Attack	Sudden Death	Stroke	Aneurysm	Diabetes	Cancer	High Blood Pressure	High Cholesterol	Heart Failure
Father:											
Mother:											
Sister:											
Sister:											
Brother:											
Brother:											

Name of Patient: \_\_\_\_\_  
Last First M.I.

DOB: \_\_\_\_\_

## Review of Systems

### EYES

- Permanent blindness in either eye
- Cataracts
- Glaucoma
- Vision changes

### HEART

- Heart attack, What year (s): \_\_\_\_\_
- Chest discomfort/angina with physical activity
- Chest discomfort/angina at rest
- Shortness of breath with exertion
- Shortness of breath at rest
- Require more than one pillow at night to breathe well
- Heart failure or "fluid on lungs"
- Palpitations, racing or pounding heart beat
- Pauses in the heart beat
- Previously diagnosed heart rhythm disturbance
- Heart murmur
- Mitral valve prolapse

### BLOOD

- Bleeding or bruising tendency
- Frequent or severe nose bleeds
- Blood disorder
- Specify: \_\_\_\_\_
- Previous blood transfusion
- Recent fever
- History of hepatitis or other communicable disease

### STOMACH/INTESTINES

- Stomach ulcer or peptic ulcer
- Dark, tarry stools

### NERVOUS SYSTEM

- Frequent headaches or migraines
- Epilepsy or seizures
- Depression
- Nervous disorder
- Memory loss

### CIRCULATION

- Discoloration of feet or legs
- Pain in legs or buttocks with exercise
- Non-healing sores or ulcers on feet or legs
- Blood clot in artery
- Blood clot in leg vein
- Ankle or leg swelling
- Phlebitis of leg veins
- Sudden visual disturbances in either eye
- Weakness or paralysis of one side of the body
- Temporary speech loss or difficulty talking
- Stroke
- Dizziness, light-headedness or "black out spells"
- Aneurysm of any blood vessels
- "Mini-strokes" or TIA's

### LUNGS

- Asthma or wheezing
- Pneumonia
- Emphysema
- Chronic cough
- Coughing up blood

### KIDNEY/URINARY TRACT

- Kidney disease or failure
- History of Kidney dialysis  
What year: \_\_\_\_\_
- Kidney stones or infection
- Blood in urine during past year

### METABOLISM/ENDOCRINE

- Thyroid disorder
- Gout
- Recent weight gain or loss (> 10 lbs)

### MUSCLES/BONES/JOINTS

- Arthritis or other joint disease

### REPRODUCTIVE (for women)

Are you or might you be pregnant?

- Yes  No

Date (or year) of last period: \_\_\_\_\_

### REPRODUCTIVE (for men)

Erectile Dysfunction?

- Yes  No



## Form 5, Important Message about Our Financial Policy and Billing

Dear Patient,

Our goal is to provide you with very good care and service. Attached is a copy of our financial policy. It is very important you review this policy. If you have any questions before your appointment please call (480) 844-0401 to speak with a financial counselor.

Each visit, during the registration process, your statement or account balance will be reviewed with you by a financial counselor or registrar prior to services rendered. The final part of your registration process will be to review your financial obligations to ensure the accuracy of your bill. We will ask you to pay any co-payments, deductibles, and outstanding balances at this time.

In addition, your registration process will include updating your demographic, insurance and health information. This process will improve the quality of patient information we use to care for you.

Our Mission states we will provide care to our patient regardless of ability to pay. This means we will work collaboratively with patients who are under financial hardship to develop fair and reasonable payment plans. Financial hardship is determined by policy and is a formal process that must be a joint effort between a financial counselor and the patient. A patient who has the ability to pay and has not been formally determined to be in financial hardship, is expected to pay at the time of service and maintain no outstanding balance.

Our policy states that any account balance remaining **after** insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time. All co-pays, deductibles, and previous account balances must be paid before additional services will be rendered.

We hope this brief overview is helpful. We are excited about the opportunity to provide you with very good care and service. If you have any questions or concerns, please contact Mykl Garrett, CEO at 480-993-1060. Thank you.

### **Billing Questions**

222 S. Power Road, Suite 102  
Mesa, AZ 85206  
(480) 844-0401

## **TRI-CITY CARDIOLOGY CONSULTANTS, P. C. FINANCIAL POLICY**

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We are dedicated to providing you with very good care and service, and we regard your understanding of our financial policies as an essential element of your care.

### **Patient Responsibilities**

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Tri-City Cardiology (TCC) of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments **directly** to TCC. Any payments sent directly to the patient should be forwarded to TCC with the Explanation of Benefits to prevent your account being subject to collection procedure and legal action. Authorization must be signed at the initial visit, upon any change in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that TCC is a participating provider with your insurance company. All referrals to TCC are to be obtained **prior** to your appointment. This will prevent your appointment from needing to be rescheduled.

### **Payment Policy**

#### Insured

All co-pays and deductibles must be paid before services are rendered. If unable to pay your co-pay at the time of service, your appointment may be rescheduled. Non-contracted insurance claims will be submitted to the insurance company as a courtesy to you however the charges remain your responsibility. If no response is received from your insurance within 60 days, payment must be made by you.

#### Non-Insured

TCC requires full payment at the time of service unless prior arrangements have been made with our Billing Office. These arrangements may consist of three equal payments (first payment required at the time of service).

#### Balances Due

Patient balances remaining **after** insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

#### Medical Forms

TCC requires full payment of \$50.00 at the time your Insurance forms (FMLA, FAA Clearance, Disability, etc.) are dropped off for completion. Completion of forms are **not** paid by your insurance company.

#### Hospitalizations

It is your responsibility to notify your insurance company and primary care physician's office in the event of an unscheduled hospitalization. It is also your responsibility, not the hospital's to provide TCC with your insurance information.

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**Print Name**

**Date of Birth**

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**Signature**

**Today's Date**

**Form 6, AUTHORIZATION TO RELEASE HEALTH INFORMATION**  
**Tri-City Cardiology Consultants, P.C.**

\_\_\_\_\_ 6750 East Baywood Ave. Suite 301, Mesa AZ 85206 Phone (480) 835-6100 Fax (480) 461-4243

\_\_\_\_\_ 1520 South Dobson Rd. Suite 209, Mesa AZ 85202 Phone (480) 835-6100 Fax (480) 461-4243

\_\_\_\_\_ 10238 East Hampton Ave. Suite 401, Mesa AZ 85209 Phone (480) 835-6100 Fax (480) 461-4243

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ I hereby authorize Tri-City Cardiology to RECEIVE medical records from the Physician/Provider below

Physician/Provider/Patient Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize the release of photocopies of the following medical records: For the purpose hereof, "medical records" shall include all:

- \_\_\_ 1. Confidential HIV-related information (as defined in A.R.S section 36-6610)
- \_\_\_ 2. Confidential communicable disease-related information (as defined in A.R.S section 36-6610)
- \_\_\_ 3. Confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ)
- \_\_\_ 4. Confidential mental health diagnosis/treatment information
- \_\_\_ 5. Confidential genetic testing information (as defined in A.R.S section 12-2801)

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Tri-City Cardiology Consultants, P.C. in writing to that effect. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original. Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. Once this information is released, it may be re-disclosed by the recipient and may no long be protected information.

Medical Records Requested (check one)

\_\_\_\_\_ ALL Records \_\_\_\_\_ Past Two Years \_\_\_\_\_ Testing \_\_\_\_\_ Specific \_\_\_\_\_ Pertinent Information (recent)

**IMPORTANT INFORMATION/NOTICES FOR THE RECIPIENT:**

The attached photocopies of medical records are sent to you pursuant to the authorization and request the patient specified on the front side of this consent submitted to Tri-City Cardiology Consultants, P.C.

If you received any medical records and/or x-ray films which included confidential HIV-related information or confidential communicable disease-related information as defined in A.R.S. Section 36-661, the following notice on re-disclosure applies under Arizona law:

**THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS WHICH ARE PROTECTED BY STATE LAW THAT PROHIBITS FURTHER RE-DISCLOSURE OF THE INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY LAW, A.R.S. SECTION 36-664 (G).**

If you received any medical records and/or x-ray films which included confidential alcohol or drug abuse-related information as defined in 42 CFR Section 2.1 et seg., the following notice on re-disclosure applies under the federal law.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART II). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY 42 CFR PART II. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

**THIS FORM MUST BE COMPLETELY FILLED OUT TO PROCESS**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN/POA SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RECORDS PREPARED AND TRANSMITTED/MAILED BY \_\_\_\_\_

**Form 6, AUTHORIZATION TO RELEASE HEALTH INFORMATION**  
**Tri-City Cardiology Consultants, P.C.**

\_\_\_\_\_ 6750 East Baywood Ave. Suite 301, Mesa AZ 85206 Phone (480) 835-6100 Fax (480) 461-4243

\_\_\_\_\_ 1520 South Dobson Rd. Suite 209, Mesa AZ 85202 Phone (480) 835-6100 Fax (480) 461-4243

\_\_\_\_\_ 10238 East Hampton Ave. Suite 401, Mesa AZ 85209 Phone (480) 835-6100 Fax (480) 461-4243

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ I hereby authorize the RELEASE of photocopies of the following medical records: For the purpose hereof, "medical records" shall include all:

Physician/Provider/Patient Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize the release of photocopies of the following medical records: For the purpose hereof, "medical records" shall include all:

- \_\_\_ 1. Confidential HIV-related information (as defined in A.R.S section 36-6610)
- \_\_\_ 2. Confidential communicable disease-related information (as defined in A.R.S section 36-6610)
- \_\_\_ 3. Confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ)
- \_\_\_ 4. Confidential mental health diagnosis/treatment information
- \_\_\_ 5. Confidential genetic testing information (as defined in A.R.S section 12-2801)

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Tri-City Cardiology Consultants, P.C. in writing to that effect. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original. Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. Once this information is released, it may be re-disclosed by the recipient and may no long be protected information.

Medical Records Requested (check one)

\_\_\_\_\_ ALL Records \_\_\_\_\_ Past Two Years \_\_\_\_\_ Testing \_\_\_\_\_ Specific \_\_\_\_\_ Pertinent Information (recent)

**IMPORTANT INFORMATION/NOTICES FOR THE RECIPIENT:**

The attached photocopies of medical records are sent to you pursuant to the authorization and request the patient specified on the front side of this consent submitted to Tri-City Cardiology Consultants, P.C.

If you received any medical records and/or x-ray films which included confidential HIV-related information or confidential communicable disease-related information as defined in A.R.S. Section 36-661, the following notice on re-disclosure applies under Arizona law:

**THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS WHICH ARE PROTECTED BY STATE LAW THAT PROHIBITS FURTHER RE-DISCLOSURE OF THE INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY LAW, A.R.S. SECTION 36-664 (G).**

If you received any medical records and/or x-ray films which included confidential alcohol or drug abuse-related information as defined in 42 CFR Section 2.1 et seg., the following notice on re-disclosure applies under the federal law.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART II). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY 42 CFR PART II. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

**THIS FORM MUST BE COMPLETELY FILLED OUT TO PROCESS**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN/POA SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RECORDS PREPARED AND TRANSMITTED/MAILED BY \_\_\_\_\_

**Form 7, AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION**

Tri-City Cardiology Consultants, P.C.

Patient Name \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care, to the individuals listed below, if unable to contact me. This authority will be in effect for one (1) year.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Please Initial below:

- \_\_\_\_\_ No, I only want my medical information released to myself
- \_\_\_\_\_ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers \_\_\_\_\_
- \_\_\_\_\_ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_

• FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communication barrier
- \_\_\_\_\_ Care provided was emergent
- \_\_\_\_\_ Other

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Form 8, PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE**  
Tri-City Cardiology Consultants, P.C.

I have received a copy of Tri-City Cardiology Consultant's, P.C., Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name if Signed by Individual Other Than Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

Tri-City Cardiology Consultants, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY

Tri-City Cardiology Consultants, P. C. (the “Practice”) is dedicated to maintaining the privacy of your personal health information. Each time a patient visits the office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practices will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **TREATMENT:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **PAYMENT:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **HEALTH CARE OPERATIONS:** We may use and disclose health information to operate our business. For example your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **APPOINTMENT REMINDERS:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
5. **TREATMENT OPTIONS:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **BUSINESS ASSOCIATES:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases
- For workers’ compensation or similar programs as required by law
- To authorities when we suspect abuse, neglect, or domestic violence
- To health oversight agencies
- For certain judicial and administrative proceedings pursuant to an administrative order
- For law enforcement purposes

- To a medical examiner, coroner, or funeral director
- For the facilitation of organ, eye, or tissue donation if you are an organ donor
- For research purposes under strictly limited circumstances
- To avert a serious threat to your health and safety or that of others
- For governmental purposes such as military service or for national security
- In the event of an emergency or for disaster relief
- In any other instance required by law

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

**YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.**

DONNA DEPONTE, PRIVACY OFFICER, 222 S. POWER ROAD, STE 101 MESA, AZ 85206

1. **RESTRICTIONS ON USE AND DISCLOSURE:** You have the right to request restrictions on how we use and disclose your health information. This includes request to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **ACCESS:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **RECORD AMENDMENT:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures practice had made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **COPY OF NOTICE:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at (480) 835-6100. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

## Form 9, SLEEP EVALUATION FORM

Tri-City Cardiology Consultants, P.C.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Trouble sleeping can impact your heart and your blood pressure. In an effort to promote cardiovascular health, we are committed to identifying those of our patients with sleep disorders.

Please take a moment to place an X in the appropriate column next to each statement below. If you have marked “yes” next to two or more of these statements, further evaluation of your sleep patterns may be warranted. Your physician will be happy to further discuss this with you during your appointment.

	Yes	No
1. I snore often or disturb others with my snoring.		
2. I have been told of pauses or stopping breathing during sleep.		
3. I have difficulty waking up or I am sleepy during the day.		
4. I am tired during the day, take naps or fall asleep during activities like reading, working on a computer or watching TV.		
5. I have headaches when I wake (more than 2 times per week).		
6. I often wake more than 3 times a night.		
7. I often wake to use the bathroom more than twice a night.		
8. I am being treated for at least one of the following conditions: high blood pressure, heart failure, or atrial fibrillation.		
9. I am prescribed to take 3 or more medicines for blood pressure.		
10. I am being followed for diabetes or pre-diabetes.		

# FORM 10, Peripheral Vascular Health Screening Questionnaire


Tri-City Cardiology Consultants, P.C.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Peripheral Vascular Disease (PVD) is a common circulatory problem in which vessels carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.**

**Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PVD.**

**Please circle “Yes” or “No” on the following questions and check all boxes that apply:**

<p>1. Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation? <span style="float: right;">Yes No</span></p>	<p>6. If you have pain, does the pain subside with rest? <span style="float: right;">Yes No</span></p>
<p>2. Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? <span style="float: right;">Yes No</span> If yes, dates: _____</p>	<p>7. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? <span style="float: right;">Yes No</span></p>
<p>3. When you walk, do you experience aching, cramping or pain in your arms, legs, thighs, or buttocks? <span style="float: right;">Yes No</span></p>	<p>8. Do you have any painful sores or ulcers on legs or feet that do not heal? <span style="float: right;">Yes No</span></p>
<p>4. If you answered Yes to #3, when do you feel the pain:</p> <p><input type="checkbox"/> After walking 1 block</p> <p><input type="checkbox"/> Climbing a flight of stairs</p> <p><input type="checkbox"/> After walking 100 yards</p> <p><input type="checkbox"/> Walking at increased speed</p>	<p>9. Are you legs or arms pale, discolored or bluish? <span style="float: right;">Yes No</span></p>
<p>5. If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.</p> <div style="text-align: center; margin-top: 20px;">  </div>	<p>10. Check all that apply:</p> <p><input type="checkbox"/> I am a current smoker</p> <p><input type="checkbox"/> I have a history of smoking</p> <p><input type="checkbox"/> I have diabetes</p> <p><input type="checkbox"/> I have a family history of diabetes</p> <p><input type="checkbox"/> I have high cholesterol</p> <p><input type="checkbox"/> I have a family history of high cholesterol</p> <p><input type="checkbox"/> I have high blood pressure/hypertension</p> <p><input type="checkbox"/> I have a family history of high blood pressure/hypertension</p> <p><input type="checkbox"/> I have coronary artery disease (CAD)</p> <p><input type="checkbox"/> I have a family history of coronary artery disease</p> <p><input type="checkbox"/> I have had a stroke/mini-stroke/TIA</p> <p><input type="checkbox"/> I have a family history of stroke/mini-stroke/TIA</p>



## **Form 11, Important Message about Managing Your Medications, Prescriptions and Refill Requests**

Dear Patient,

Our goal is to provide you with very good care and service. We know information about medications and managing your medication needs is important to you. We need to work together to ensure a safe and accurate medication regimen for you.

### **Office Visits:**

At every office visit we want to address your medication and prescription needs:

**Please bring all of your prescription medication bottles to every physician visit. This is the most accurate way for us to maintain your medication profile.**

**If you have been discharged from the hospital in the last sixty (60) days, it is important to bring your hospital discharge instructions that contains your most recent medication instructions.**

During your visit, please be prepared to answer the following questions:

- What medications are you taking?
- Have you started any new medications since your last visit to our office?
- Do you have any medication needs today?
- Do you need a refill authorization faxed to your pharmacy for any of your medications?
- Have you recently asked your local or mail order pharmacy for a refill authorization request?
- Do you need new prescriptions written today for medications you are taking?
- Do you have enough authorized refills to hold you until your next appointment?

If you use a mail order pharmacy:

- Do you need a prescription for a 90-day supply and authorized refills to hold you at least 30 days beyond your next scheduled appointment?
- Do you need a prescription to fill at a local pharmacy for a supply adequate until the mail order prescription is filled?

Information about Medications During Your Visit: Has your doctor prescribed any medication for you during this visit? If so, be sure that you address the following questions before you finish your physician appointment or ask your pharmacist:

- Do you know the name of the medication?
- Do you know how the medicine helps you?
- Do you know when to take the medicine, for instance, do you know what to do if you miss a dose---do you take two when you remember or just skip the missed dose?
- Do you know what are possible side effects associated with the medicine, for example, is it likely to make you drowsy or nauseated?
- Is the drug likely to interact with any over-the-counter, nonprescription drugs you may be taking, or with alcohol?

### **Managing Refill Prescriptions:**

**All refill requests for medication prescribed by your Tri-City physicians should be made through your pharmacy. Call your pharmacy if you need a refill authorization (if you are out of refills), your pharmacist is in the best position to safely and accurately coordinate the request with our staff.**

Read the information on your prescription bottle label. The label contains important refill information such as last refill date, refills remaining and expiration date of the prescription.

Request your prescription refill at least 7 days prior to running out of medication. If you know your prescription has expired or has no more refills, initiate the refill request through your pharmacy at least two weeks before you need it filled.

If your prescription medication needs a prior authorization from your Tri-City physician for insurance coverage so the prescription can be refilled, initiate the request at least 30 days before you need your refill.

If you use a mail order pharmacy, initiate a refill authorization request through your mail order pharmacy. Allow yourself at least 30 days before you run out of medication. If you need a supply of medication to hold you over until the mail order medication is available, you may contact us for a prescription that can be filled at a local pharmacy.

**You may notify us through our Web Site at [www.tricitycardiology.com](http://www.tricitycardiology.com).** Please notify your pharmacy first before using this site. You can email us through our web site to let us know that you have initiated a refill authorization request or prior authorization request for insurance coverage. Go to our web site and at the home page on the left side bar there is a Prescription Refills tab.

If you have any questions or concerns, please contact Mykl Garrett, RPH, CEO at 480-993-1060 or go to our Contact Us tab on our Web Site at [www.tricitycardiology.com](http://www.tricitycardiology.com). Thank you.



## DIRECTIONS AND MAPS

**Main Phone:** (480) 835-6100

**Office Addresses:**

BANNER HEART HOSPITAL CAMPUS

6750 East Baywood · Suite 301 · Mesa, AZ 85206

Directions:

- Traveling East or West on Highway 60 in East Mesa, take the Power Road exit
- Turn North onto the Power Road exit
- Travel through the stop lights at Southern Ave., Broadway Rd. and Baywood Ave. Immediately after Baywood Ave., take the entrance into the Banner Heart Hospital
- Travel up the ramp to the top level of the Banner Heart parking deck. Park and enter the hospital on the lobby level. There are two sets of elevators off the main lobby. Take either set of elevators to the 3<sup>rd</sup> floor



Note: Free valet parking is available on the West entrance of the Heart Hospital. Enter North off of Baywood just West of the Power Road and Baywood intersection.

BUSINESS OFFICE

222 South Power Road · Suite 102 · Mesa, AZ 85206

Directions:

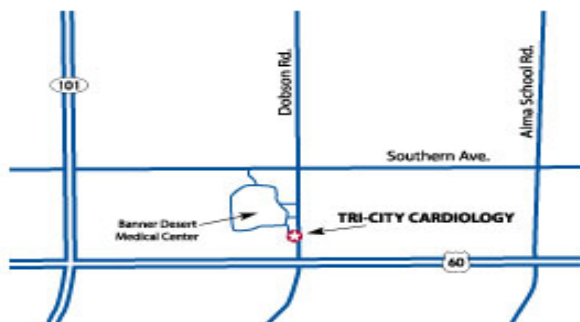
- Traveling from the East or West on Highway 60 in East Mesa, take the Power Road exit
- Turn North onto Power Road
- Travel through the stop lights at Southern Ave., Broadway Rd. and Baywood Ave. Immediately after Baywood Ave., take the entrance into the Banner Heart Hospital
- Make a right turn before you reach the ramp that leads to the top level of the Banner Heart parking deck. Park and enter Suite 102 on the South side of the administrative building
- Check in or ring the bell at the front desk

## BANNER DESERT MEDICAL CENTER CAMPUS

1520 South Dobson Road · Suite 209 · Mesa, AZ 85202

### Directions:

- Traveling from the East or West on Highway 60 in Mesa, take the Dobson Road exit
- Turn North onto Dobson Road and at the first stop light intersection turn West (Left) into the Desert Samaritan Medical Center Campus
- Go 50 yards to the first (T) intersection and turn left onto a circle drive. Take the circle drive around the South side of the hospital until you reach a stop sign. Building 1520 should be the third building on your left
- Turn left into the under building parking lot and park
- There are two elevators, one on the Northeast side of the parking lot and one on the Southwest side of the parking lot. Take an elevator to the 2<sup>nd</sup> floor. Our office is Suite 209 on the Southeast side of the open air atrium.



## MOUNTAIN VISTA MEDICAL CENTER CAMPUS

10238 E. Hampton Ave. · Suite 401 · Mesa, AZ 85209

### Directions:

- Traveling from the East or West on Highway 60 in Mesa, take the Crismon Road exit (Exit 192) and turn north
- Continue to East Hampton Avenue and take a right
- Take the last entrance past the hospital to the “Medical Office Building” located on your left
- The building is marked “East”

