



2311 M Street, NW
 Suite 101
 Washington, DC 20037
 (202) 466-3000 Office
 (202) 466-3001 Fax
 Portal: www.YourHealthFile.com
 Website: www.ccspllc.com

TODAY'S DATE: ____/____/____ PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____	MEDICAL RECORDS MAY BE RELEASED TO: (full name/ relationship to patient/ phone no) _____ BEST CONTACT: <input type="checkbox"/> Home Phone / <input type="checkbox"/> Cell Phone / <input type="checkbox"/> Work Phone / <input type="checkbox"/> Mail / <input type="checkbox"/> Email _____
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PATIENT INFORMATION

PATIENT'S (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)	MARITAL STATUS
_____	_____	_____	_____	_____

RACE/ ETHNICITY	PRIMARY LANGUAGE	DOB (mm/dd/yyyy)	AGE	GENDER (check below)	EMAIL ADDRESS
_____	_____	____/____/____	____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	_____

STREET ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NO.	HOME PHONE NO.	MOBILE PHONE NO.	EMPLOYER	WORK PHONE NO.
_____	_____	_____	_____	_____

INSURANCE INFORMATION

(Please give your ID and Insurance card to the receptionist.)

SUBSCRIBER NAME (as displayed on card)	DOB (mm/dd/yyyy)	ADDRESS (if different)	SUBSCRIBER SOCIAL SECURITY NO.
_____	____/____/____	_____	_____

PRIMARY INSURANCE COMPANY	PRIMARY POLICY NO.	SECONDARY INSURANCE COMPANY	SECONDARY POLICY NO.
_____	_____	_____	_____

PHARMACY NAME	PHARMACY PHONE NO.	PHARMACY ADDRESS
_____	_____	_____

IN CASE OF EMERGENCY

NAME OF RELATIVE OR LOCAL FRIEND	RELATIONSHIP TO PATIENT	PRIMARY PHONE NO.	WORK PHONE NO.
_____	_____	_____	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Capital Cardiovascular Specialists and/or insurance companies to release any information required to process my claims.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the physician's notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ Patient Printed Name	_____ Patient Signature	____/____/____ Today's Date
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COMPREHENSIVE PATIENT HISTORY

Patient Name:		Today's Date:	
Birth Date:		Referring Physician:	
What type of complaint or medical problem is the reason for requesting this visit?	<hr/> <hr/> <hr/> <hr/>		
How long have you had this problem? Explain.	<hr/> <hr/>		
Tell us about yourself:		Immunization: yes/no	
Marital status: _____ Children: _____ Pets: _____ Job/Profession: _____ Type of diet: _____ Travel in past 30 days: _____ Hours of sleep per night: _____	How many days a week do you exercise: _____ Use of caffeine: _____ (Rarely, Moderate, Daily) Use of alcohol: _____ (Rarely, Moderate, Daily) Use of tobacco: _____ (Rarely, Moderate, Daily) Use of Drugs: _____ if so, Type: _____ Frequency: _____	Pneumococcal: _____ Year: _____ Hepatitis A: _____ Year: _____ Hepatitis B: _____ Year: _____ Tetanus: _____ Year: _____ Transfusions: Have you ever received a blood transfusion: _____ When: _____	
Past medical history: (check one)			
Have you ever had the following? Diabetes: <input type="checkbox"/> Yes / <input type="checkbox"/> No Hypertension: <input type="checkbox"/> Yes / <input type="checkbox"/> No High cholesterol: <input type="checkbox"/> Yes / <input type="checkbox"/> No Stroke: <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart failure: <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart attack: <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart valve problem: <input type="checkbox"/> Yes / <input type="checkbox"/> No Heart rhythm problem: <input type="checkbox"/> Yes / <input type="checkbox"/> No Atrial fibrillation: <input type="checkbox"/> Yes / <input type="checkbox"/> No Kidney disease: <input type="checkbox"/> Yes / <input type="checkbox"/> No Blood clot in leg or lung: <input type="checkbox"/> Yes / <input type="checkbox"/> No Cancer: <input type="checkbox"/> Yes / <input type="checkbox"/> No	Please list other current medical conditions: _____ _____ _____ Please list any prior/past medical conditions: _____ _____ _____ Please list any surgeries/procedures; reason for and date of surgery/procedure: _____ _____ _____		
Medications: (prescription name, dose, how often taken)		Allergies or adverse drug reactions? (list all allergies including drug related allergies and type of reaction)	
	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Patient Name: _____ DOB: _____ Today's Date: _____

Family History: (illness / condition)	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	Other
<i>Place "X" in appropriate boxes</i>								
Heart attack								
Heart rhythm problem								
Congestive heart failure								
Heart valve problem								
High blood pressure								
Diabetes								
Stroke								
High cholesterol								
Kidney disease								
Blood clot								
Cancer								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Present History: (check one)	<ul style="list-style-type: none"> • Has a doctor ever said your blood pressure was too high? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Has a doctor told you your cholesterol level was high? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Has a doctor ever told you your kidney function was abnormal? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you ever have pain in your chest or heart area? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you have heart palpitations? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Does your heart often race or beat very fast? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you ever notice extra heartbeats or skipped beats? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Are your ankles often swollen? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do cold hands or feet trouble you even in hot weather? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Has a doctor ever said you have an abnormal electrocardiogram (EKG)? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you have frequent cramps in your legs? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you often have difficulty breathing, feel short of breath or winded with exertion? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you get out of breath long before anyone else? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you sometimes get out of breath when sitting still? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you get short of breath when lying flat? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Do you ever awaken out of your sleep feeling short of breath? <input type="checkbox"/> Yes / <input type="checkbox"/> No • Have you ever fainted? <input type="checkbox"/> Yes / <input type="checkbox"/> No
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Patient Signature and today's date	Physicians Signature and today's date:



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OFFICE POLICIES

Thank you for choosing Capital Cardiovascular Specialists as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Please ask if you have any questions about our fees, our policies, or your responsibilities. Please notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

1. **Financial Responsibility:** All co-payments and past due balances are due at time of check-in.
2. **Appointment Cancellation Policy:** All same day cancellation and no shows for office visits will be charged \$50, non-invasive studies \$100, and nuclear stress test \$200.
3. **Medical Documents:** There will be a charge for all medical documents completed by the physician. FMLA/Disability forms \$50, medical records preparation fee \$50 and up, letters written by the physician \$100.
4. **Outstanding Balance Policy:** It is our office policy that all past due accounts are sent two statements. If payment is not made on the account, a single phone call will be made in an effort to make payment arrangements. If no resolution is made, the account will be sent to a collection agency or attorney, with possible discharge from the practice.
5. **Medication Refills:** To ensure that your medication needs are met in a timely manner, we request that you call our office at least one week prior to the date your medication is scheduled for renewal.
6. **Returned Checks:** The charge for a returned check is \$35 payable by cash or money order.

Printed Name: _____

Signature: _____

Date: _____



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CREDIT CARD AUTHORIZATION

At Capital Cardiovascular Specialists, PLLC (CCS), we require each patient to remit payment, in full, for all services rendered (to the extent a patient is financially liable for such services). To ensure payment is received and we do not have to place any patient account with a collection agency or law firm to pursue payment, we **require** CCS patients who have a personal responsibility to supplement health insurance costs to maintain on our encrypted and secure electronic records system, a valid major credit card or debit card. Your credit card or debit card will **ONLY** be charged any outstanding and past due balance remaining on your account, **after**:

- (1) your claim has been filed and processed;
- (2) the insurance portion(s) of the claim has/have been paid and applied to your account; and
- (3) at least one written statement detailing your outstanding patient responsibility has been mailed to you; and
- (4) more than sixty (60) days have passed since the applicable medical services were provided to you, **resulting in a past due balance.**

If your debit card or credit card, as applicable, cannot be charged to satisfy your outstanding and past due balance, a billing fee of Thirty Dollars (\$30.00) will be added to your account. Also, an "outstanding balance" fee of one and one-half percent (1.5%) of the outstanding balance will be charged for each month any portion of the balance remains unpaid after an unsuccessful attempt to charge your debit card or credit card.

ONLY PATIENTS WITH THE FOLLOWING INSURANCE PLANS ARE EXEMPT FROM THE CREDIT CARD/DEBIT CARD REQUIREMENT:

1. **100% MEDICAID (DISTRICT OF COLUMBIA OR MARYLAND OR VIRGINIA)**
2. **MEDICARE AND MEDICAID DUAL**
3. **UNITED HEALTHCARE MEDICARE AND MEDICAID DUAL**
4. **AMERIGROUP**
5. **AMERIHEALTH**
6. **MEDSTAR FAMILY CHOICE**

I (we), the undersigned, authorize and request Capital Cardiovascular Specialists, PLLC to charge my credit/debit card listed below for balances due for services rendered that my insurance company identifies as my financial responsibility.

Amex Visa Mastercard Discover

Credit Card Number _____ - _____ - _____ - _____

Expiration Date ____ / ____ / ____ Security Code (3 or 4 digit code) _____

Billing Address City _____ State _____ Zip _____

Cardholder Name (as it appears on card) _____

Signature _____ Date: ____ / ____ / ____

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a sixty (60) day notification to Capital Cardiovascular Specialists, PLLC in writing and my account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Authorized Representative (Print): _____

Authorized Representative Signature: _____ Date: ____ / ____ / ____



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MEDICAL RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

Please furnish to **Capital Cardiovascular Specialists, PLLC** (hereinafter "Facility") and/or any or all of its personnel, information and/or copies of any and all hospital and/or medical record or reports of any sort, charts, notes, x-rays, lab reports and prescription information, including the right to inspect and copy such records. Facility is to be furnished any and all other information without limitation pertaining to any confinement, examination, treatment or condition of myself, including: HIV/AIDS; STDs; substance abuse; medical; dental; mental health or other treatment, examinations, or counseling for any condition, medical, dental or psychological.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy or photocopy of this medical authorization with the same validity as though an original had been presented to you.

Name: _____

Address: _____

Phone: _____ Email: _____

Signature: _____ Date: _____



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HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
 (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Section 1. Authorization

Patient Name: _____ (Last, First, Middle) Patient DOB: ____/____/_____
 Patient Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____

Section 2. Authorization

I, _____ (patient name), authorize **Capital Cardiovascular Specialists, PLLC** to use and disclose the protected health information described below to _____ (individual seeking the information).

Section 3. Effective Period

This authorization for release of information covers the period of healthcare from:

- ____/____/____ to ____/____/_____
- 1 year
- 3 years
- 5 years
- All past, present, and future periods.

Section 4. Extent of Authorization

- I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)
- I authorize the release of my complete health records with the exception of the following information:
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/ Drug abuse
 - Other (please specify): _____

Section 5. Terms

- ❖ This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- ❖ This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
- ❖ I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- ❖ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- ❖ 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.

Notice of Privacy Practices:

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Notice of Privacy Practices Acknowledgement Page:

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

Patient's Printed Name

Patient's Signature

_____/_____/_____
Date of Authorization