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: _______/_______/_________	MEDICAL RECORDS MAY BE RELEASED TO: (full name/ relationship to patient/ phone no)
PRIMARY CARE PHYSICIAN_______________________	____
REFERRING PHYSICIAN_______________________	BEST CONTACT: ☐ Home Phone / ☐ Cell Phone / ☐ Work Phone / ☐ Mail / ☐ Email _______________________

PATIENT INFORMATION

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

RACE/ ETHNICITY	PRIMARY LANGUAGE	DOB (mm/dd/yyyy)	AGE	SEX (check below)	EMAIL ADDRESS (print)
____________	____________	______/_____/_______	________	☐ Male/☐ Female	____________

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? ______________________________

How long have you had this problem? Explain. ______________________________

Tell us about yourself:

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: ____________

Immunization: yes/no

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: ☐ Yes / ☐ No
Hypertension: ☐ Yes / ☐ No
High cholesterol: ☐ Yes / ☐ No
Stroke: ☐ Yes / ☐ No
Heart failure: ☐ Yes / ☐ No
Heart attack: ☐ Yes / ☐ No
Heart valve problem: ☐ Yes / ☐ No
Heart rhythm problem: ☐ Yes / ☐ No
Atrial fibrillation: ☐ Yes / ☐ No
Kidney disease: ☐ Yes / ☐ No
Blood clot in leg or lung: ☐ Yes /. ☐ No
Cancer: ☐ Yes / ☐ 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)**	

Patient Name:____ **DOB:**____________________________ **Today's Date:** _______________________

Family History: (illness / condition)	**Family Member**							
Place "X" in appropriate boxes	**grandparents**	**father**	**mother**	**brother**	**sister**	**son**	**daughter**	**Other**
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)

- Has a doctor ever said your blood pressure was too high? ☐ Yes / ☐ No
- Has a doctor told you your cholesterol level was high? ☐ Yes / ☐ No
- Has a doctor ever told you your kidney function was abnormal? ☐ Yes /.☐ No
- Do you ever have pain in your chest or heart area? ☐ Yes / ☐ No
- Do you have heart palpitations? ☐ Yes / ☐ No
- Does your heart often race or beat very fast? ☐ Yes / ☐ No
- Do you ever notice extra heartbeats or skipped beats? ☐ Yes / ☐ No
- Are your ankles often swollen? ☐ Yes / ☐ No
- Do cold hands or feet trouble you even in hot weather? ☐ Yes / ☐ No
- Has a doctor ever said you have an abnormal electrocardiogram (EKG)? ☐ Yes / ☐ No
- Do you have frequent cramps in your legs? ☐ Yes / ☐ No
- Do you often have difficulty breathing, feel short of breath or winded with exertion? ☐ Yes / ☐ No
- Do you get out of breath long before anyone else? ☐ Yes / ☐ No
- Do you sometimes get out of breath when sitting still? ☐ Yes / ☐ No
- Do you get short of breath when lying flat? ☐ Yes / ☐ No
- Do you ever awaken out of your sleep feeling short of breath? ☐ Yes / ☐ No
- Have you ever fainted? ☐ Yes / ☐ No

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