10413 Greenbriar Parkway, Oklahoma City, OK 73159 • (405) 691-4665 / Fax (405) 378-7628

Demographic Information:

Patient Name: ____
Last First Middle

Address: ____

Zip Code: __________ City: ____________________ State: ______________

Home Phone #: (   ) __________ Work Phone #: (   ) __________ Cell Phone#: (   ) ______________

Preferred Method of Contact: Home# Cell# Work# E-mail Text Message Patient Portal Other __________

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Marital Status: (circle one) Single Married Divorced Widowed Other

Emergency Contact Name: ________________ Relationship: ________________

Emergency Contact Phone: ________________ Family Physician: ________________

Employer Name: ________________ Family physician Phone: ________________

Employer Phone: ________________

Responsible Party Information:

Responsible Party Name: ____
Last First Middle

Relationship to Patient: ____________________

Address: ____

Date of Birth: ________________ Social Security # _____-_____-_____

Sex: (Circle one) Male Female Phone: ________________

Online Access to your Medical Records:

You will have 24/7 online access to your medical records through our secure patient portal. You must provide an e-mail address to establish your portal account. Please provide your e-mail address below; it will not be used for any purpose other than to create your patient portal account. It will not be sold or shared with outside parties; we adhere to strict HIPAA regulations and place the utmost respect on your privacy.

E-mail: ____

O **Declined: I am aware of the availability of a patient portal, but do not have e-mail and/or do not wish to access my medical records online.**

WE ARE REQUIRED TO COLLECT THE FOLLOWING INFORMATION. IF YOU DO NOT WISH TO PROVIDE THIS INFORMATION, PLEASE SELECT "DECLINED".

Ethnicity: o Hispanic/Latino o Not Hispanic/Latino o Declined

Race: o American Indian/Alaska Native o Asian o Black/African American o Pacific Islander o White o Other o Declined

Preferred Language: o English o Spanish o Arabic o Chinese o Other ________________

Patient Signature: ____

PAYMENT POLICY

Thank you for choosing us as your specialty care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Self-Pay. If you do not have current insurance coverage, we offer our services at a reduced rate as a courtesy to you. A fee schedule is available upon request. All fees must be paid in full on the date of service. Acceptable forms of payment are cash, debit or credit. Personal checks are not accepted.

Lab Services. Any lab services done in office will be billed to your insurance company (unless paid in advance at fee-for-service rate). You are responsible for any balance owed after your insurance pays.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your insurance claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. Please help us to serve you better by keeping your regularly scheduled appointment. If you cannot make your appointment, please cancel at least 24 hours in advance. If you no-show for an appointment, you will be charged $25 per occurrence. 3 no-shows are grounds for dismissal from the practice. There will be a $50 reinstatement fee to be paid before being scheduled.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____

Name of Patient

______________________________________ _______________

Signature of Patient or Responsible Party Date

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NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law, and outlining any right regarding my health information.

I authorize Heart Solutions of Oklahoma to release my medical records or any medical information on my behalf to the following: (Please specify name(s)):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

I wish to place the following restriction(s) on disclosure of my health information:

____

____

Name: (please print): ______________________________

Signature: ______________________________

Relationship (if other than patient): ______________________________

This authorization is valid from: _____/_____/_____ to _____/_____/_____.

Internal Use Only

If patient or patient's representative refuses to sign acknowledgment, please document date and time notice was presented to the patient and sign below.

Date/Time form was presented _____/_____/_____ _____: _____ am pm

Signed: ______________________________

Office Policies and Procedures

Office Hours:
Monday thru Thursday 7:30 a.m. – 4:30 p.m. and Friday 7:30 a.m. to 12:30 p.m. We are closed on major holidays.

Appointments:
If you must cancel your appointment, kindly allow 24 hours' notice. Any patient who is late for a scheduled appointment may be asked to wait to be seen, or may be asked to re-schedule their appointment.

During Your Visit:
The use of recording devices is not allowed in the clinic area. This includes tape recorders, cameras, video recorders and cell phones.

No-Show Policy:
Any patient who fails to appear for 3 scheduled appointments without appropriate notice may be dismissed from the practice. There will be a reinstatement fee of $50 to be scheduled again. Each subsequent no-show will incur a $25 fee per occurrence.

Refill Requests and Phone Messages:
You may request prescription refills online through your patient portal account (preferred). Alternately, you may ask your pharmacy to fax a refill request to our office. Our fax number is (405) 378-7628. Please request refills at least one week BEFORE you run out of your medication. Allow at least **24-48 hours** for your request to be completed if submitted electronically. Allow at least 5 business days for refills requested through your pharmacy. Any phone message that are left for the nurse will be returned as soon as possible. Please keep in mind that the nurse is required to assist the physician and other staff with patients that are being seen in the clinic or hospital and may not be available at the time of your call. If you feel that the reason for your call is urgent, please inform the receptionist of the nature of your call and we will arrange for your call to be answered or returned promptly. **REFILL REQUESTS ARE NOT CONSIDERED URGENT.**

Medication Samples:
Samples may or may not be given, on a case-by-case basis, determined by the physician/provider. All patients are required to schedule an appointment if requesting medication, including medication samples.

Referrals:
If a referral is required by your insurance company prior to any specialty visits, please make sure that the referral has been completed by the physician prior to your appointment with us. Otherwise, the cost of the visit may not be covered. It may be necessary for you to see your primary care physician before any referrals can be made for you. Please contact your insurance provider for any questions that you may have regarding referrals.

Payments and Insurance:
All payments, including co-payments, deductibles, co-insurance and private pay are due at the time of service. We reserve the right to refuse an appointment if prior arrangements have not been made and you are not prepared to pay the required amount. Please inform us of any changes in your insurance coverage. There is a $25.00 returned check fee.

Medical Records:
Medical records may be provided after a medical release form is completed and signed by the patient. There is a 0.25 fee for each page that is copied. Please allow 7-10 business days to receive copies of medical records. There is no fee for records that are requested by another physician. Medical records requested via CD-ROM will require a $5.00 fee.

Patient Paperwork:
Due to the extensive time required, there is a $35.00 fee for filling out disability paperwork. There is a $25.00 fee for completing all other paperwork. This fee must be paid prior to paperwork completion. Please allow 7-10 business days for any patient paperwork that needs to be filled out, including work/school releases.

Signature: ______________________________ Date: ____________________

CONSENT AGREEMENT

FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to **Heart Solutions of Oklahoma** (referred to as provider) providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating provider as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.

You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling) or in writing (to **Heart Solutions of Oklahoma**). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary

Print Name:____________________________________

Signature:____________________________________

Date:____________