Heart&Rhythm

Himal Shah, MD
1100 S. Dobson Rd, Suite A-105, Chandler, Arizona 85286
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Phone: (480) 289-4550 Fax: (480) 289-4551

Last Name: _____ First Name: _____ MI: _____ Sex: ☐ M ☐ F

DOB: _____ SSN: _____Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Race: _____ Language: _____ Dominant Hand: Right Left Both

Home: (____) _____ Cell: (____) _____ Work: (____) _____

E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (____) _____

Referring Physician: _____ Phone: (____) _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____

(Emergency Contact Phone Number Must Be Different Than Your Phone Number)

Primary Insurance: _____ **Secondary Insurance:** _____

Member ID: _____ **Member ID:** _____

Group: _____ **Group:** _____

Insured Name: _____ **Insured Name:** _____

Relationship to patient: _____ **Relationship to patient:** _____

Primary Insured DOB: _____ **Primary Insured DOB:** _____

Pharmacy: _____ Phone: (____) _____

Address: _____ Cross Roads: _____

City: _____ State: _____ Zip: _____

Signature: ×_____**Date:** _____

HEART & RHYTHM SOLUTIONS, LLC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient Date of Birth: _____ **Patient Social Security Number:** _____

Person(s) or Organization(s) authorized to receive/Disclose health information:

Person (s) or Organization authorized to receive/disclose information:

HEART & RHYTHM SOLUTIONS, LLC

1100 S. DOBSON RD SUITE A105

CHANDLER AZ 85286

480-289-4550 Fax: 480-289-4551

Specific description of the information that may be used or disclosed (including dates)

- Complete Medical Record
- Lab Reports
- Radiology Reports

I understand that this authorization will expire 1 year from date of signature.

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by written notification.

I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable).

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations the information described above may be redisclosed and would no longer be protected by these regulations.

Patient Guardian Name: _____

Patient/guardian signature: _____ **Date:** _____

NOTE: You have the right to know specifically what information you are authorizing to release. You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release/receive information. You have the right to know who is going to use it or what it is going to be used for.

HEART & RHYTHM SOLUTIONS, LLC

OFFICE POLICY ON FAILED APPOINTMENTS

If you are more than 30 minutes late for your appointment, we reserve the the right to reschedule your appointment. A "no show" fee of $30.00 may apply if you do not call to cancel or reschedule your appointment within 24 hours of your scheduled time.

FAMILY & MEDICAL LEAVE ACT (FMLA) AND DISABILITY FORMS:

Please allow **at least 7-10 days** for review and completion of forms.

CARDIAC CLEARANCE:

Please have the requesting physician's office send us the request **at least 10 days prior** to your scheduled surgery.

PRESCRIPTION REFILLS:

Please allow us **at least 48 hours** for medication refills.

INSURANCE POLICY

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to insurance carriers we are contracted with. You are responsible for all co pays, deductibles and charges not covered by insurance. All other carriers are subject to payment at the time of service. Please understand that we cannot as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS;

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnosis, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for the release of the information.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT

Patient Name: _____

Patient/Guardian Signature: _____

Heart & Rhythm Solutions LLC

IMPORTANT SUMMARY NOTICE OF THE PRIVACY OF YOUR HEALTH INFORMATION

Patient Name: _____ **Patient DOB:** _____

Your Privacy is important to us. We record information about you so that we may provide you with quality medical care. We are committed to protecting this information. The notice of privacy practices describes your rights with regards to your health information, as well as we may use your health information. This is a summary of the more detailed information contained in your notice of privacy practices.

YOUR RIGHTS INCLUDE:

1. A right to amend your health information
2. A right to request restrictions on what information we use or how we disclose your health information
3. A right to see an accounting of certain disclosures we have made of your health information.
4. A right to obtain access to your health information with limited exceptions. (A notarized request, an appointment for access, appropriate advance notice, and a cost based fee for expenses is delineated by law).
5. A right to receive a paper copy of our notice of privacy practices

This right does have special restrictions and you may request and read the full notice at anytime. We may use your health information and/or records to:

1. Plan for your care and help your health care providers communicate and work together for you
2. Submit bills to pay for your care.
3. Help health care payers or medical insurance companies make sure services were provided.
4. Help improve the quality of your health care
5. Disclose information to certain officials or organizations as required by law.

Everyone who is trained or has access to your information is bound by your confidentiality requirements and signs a confidentiality agreement. We encourage you to read the notice and contact us if you need additional information.

I have received the Notice of Privacy Practices at Heart and Rhythm Solutions LLC

Patient/Guardian Signature: _____ **Date:** _____

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22707 S. Ellsworth Rd, Suite H-105, Queen Creek, Arizona 85242
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PATIENT FINANCIAL RESPONSIBILITY
CANCELLATION & NO SHOW POLICY

Attention Patients & Families:

We, the physicians at Heart & Rhythm Solutions would like to make you aware of our appointment policy. An appointment has been set aside especially for you and when that appointment is missed, that time cannot be used to treat a sick patient. When you are ill and requesting an appointment, we can offer one to you only if those who cannot make their appointment call within the appropriate time frame to inform us of cancellation.

Our policy is as follows:

Physician Appointment: In the event that you must cancel or reschedule your appointment with one of our physicians, you must do so within 24 hours of your scheduled appointment time. Failure to comply with this policy may result in a **$30 fee**. This fee must be honored prior to rescheduling your appointment. In the event that you no show to a physician's visit on three or more occasions, you may be dismissed from the practice.

Testing: In the event that you must cancel or reschedule a testing appointment in the office, you must do so 24 hours prior to your scheduled appointment time. Failure to comply with this policy may result in a **$200 fee**. This fee must be honored prior to rescheduling your appointment. In the event that you are absent from or cancel a test on three consecutive occasions, you may be unable to reschedule the test at our office. You may be referred to the hospital to have the test performed.

Echo's, Ultrasounds, ABI/Carotid appointment cancellations in less than 24 hours or no shows will be charged a **$50 fee**. Nuclear Stress Test, Pet Scan or Vein Ablation Appointment late cancellation or no shows, will be charged a **$200 fee**.

Please be advised that the fees listed above are NOT covered by your insurance company and must be paid by you personally.

Past Balances & Copays: Per your insurance, copays are due at the time of service. Any deductibles or co-insurances will be billed to you and are due at the time of receiving our billing statement. If you have a past balance at the time of an appointment, that balance will need to be paid in full, unless payment arrangements have been made, and prior to receiving future services. Balances not paid in a timely manner, will be forwarded to our collection agency.

For those of you who are prompt for your appointment times and keep your account in good standing, we extend our sincere appreciation. By taking responsibility for your appointments and services rendered, everyone can benefit.

Thank you,
Heart & Rhythm Solutions

Heart&Rhythm

2019

FINANCIAL AGREEMENT UPDATE

I, _____, was given and read a copy of the Patient Financial Responsibility, Cancellation and No Show Policy. I understand the charges that I may incur for late cancellations or missed appointments. I also understand that I am responsible for any amounts due to Heart & Rhythm Solutions for services rendered that my insurance processes as patient responsibility. I agree to pay any past balances due in a timely manner and if I cannot do so, I will contact the billing staff to set up payment arrangements.

_____ _____

Patient Signature Date

_____ _____

Witness Date