ELLAHI HEART CLINIC

DATE: _____

Please PRINT AND complete ALL sections below!

Patient Registration Information

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

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

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

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

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Who is your Family Doctor (PCP) (if different than Referring): _____

Referring Doctor Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

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

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Ellahi Heart Clinic / Atif Sohail, MD, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Ellahi Heart Clinic

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY

Atif Sohail M.D. F.A.C.C.

400 W. Arbrook Blvd. Ste 220, Arlington, TX 76014
Phone: 817-419-7220 Fax: 817-419-7222

Interventional Cardiology
Cardiovascular Diseases

FINANCIAL POLICY AND CONSENT FORM

Welcome to our office. We are glad you have selected our office to help with aspect of your medical care. So that we can better assist you we have outlined our policies about insurances, finances and payment below.
We sincerely want to make your visit with us a pleasant experience and will try our best to do so. By making our policies clear we hope to avoid any problems or misunderstandings. Please let us know if you have any question about your medical care, our policies or need further details.

Initials ____ **Financial Responsibility:** As a courtesy, we will file our charges for you with your health insurance carrier(s). Unpaid balances after insurance has processed claims will automatically become your responsibly. A statement will be mailed to you and payment is expected upon receipt. Your health insurance is a contract between you and your insurance company. Coverage cannot be guaranteed. Misunderstanding about insurance can be avoided if you understand what your policy provides. Should your acct be turned over to collections you will be responsible for all attorney fees, court cost and any other fees incurred. In addition if I default in payment of my account, and you place this balance with a 3rd party collection agency for collection, I agree to pay add on collection charges in the amount of 10%up to 33.33% of the unpaid balance. I understand in the event of default you or your agents may list my unpaid balance as a collection account on my consumer credit report.

Initials ____ **Deductibles, Co-insurance, and Co-pays:** Unless specific prior arrangements have been made payment of deductibles and co-pays, including those associated with Medicare and Medicaid will be expected at the front desk at the time of your visit.

Initials ____ **Insurance Plans Requiring Referrals:** If you're insurance carrier requires you to have a referral prior to your seeing a specialist, our office must have received the referral before your arrival. If we do not have it upon you signing in your appointment will be rescheduled or full payment must be made prior to the office visit.

Initials ____ **Non-Covered Charges:** We want to provide you with the best healthcare that we can possibly deliver; however, we find that occasionally there are certain service/devices that your doctor may prescribe as necessary that may be not covered by some insurance carriers. Until your insurance has submitted payment to us, we have no guarantee of any payment from the carrier. You will be responsible for checking coverage and any charges incurred. You will need to contact your insurance carrier with any problems concerning their payment to us.

Initials ____ **Returned Checks:** There is a $35.00 charge for all returned checks. After check has been returned twice NSF, Payment to our office will be on cash basis only.

Initials ____ **Outpatient Procedures Ordered**: Patients are financially responsible for any outpatient procedures ordered by the physician. Our office will assist in obtaining proper authorizations for the procedure indicated by your carrier prior to the date and time. You, the insured are ultimately responsible for what your coverage requires and we suggest that you contact your insurance carrier to verify your benefits & pre-authorization requirements prior to having the procedure done. Our office will not be responsible for your charges.

Initials ____ **Prescriptions**: Our office requires 5 day notice when requesting any medication refills. No refills are approved after hours or weekends! **It is the patient's responsibility to provide a current list of all medications currently taking at the time of every appointment.**

Date: ___/___/____

Ellahi Heart Clinic

ACCREDITED FACILITY IAC ECHOCARDIOGRAPHY

Atif Sohail M.D. F.A.C.C.

400 W. Arbrook Blvd. Ste 220, Arlington, TX 76014
Phone: 817-419-7220 Fax: 817-419-7222

Interventional Cardiology
Cardiovascular Diseases

Due to the rising cost of providing healthcare we are introducing our policies. Many manage care and other insurance companies require that we collect co-pays, deductibles and co-insurance from patients, not only is this the arrangement in your contract with your insurance, but it will save time, money and confusion in the long run.

"HMO" Health maintenance organizations members **cannot see a specialist without a referral** from your primary Care, Family or Internal Medicine doctor. **It is the Patient's responsibility to obtain a PCP-HMO Referral**, if you do not have a valid referral you may be seen, but the visit must be on a cash basis.

To avoid an unnecessary bill to you please present your insurance card at each visit to the front desk representative.

Un-insured Patients, payment will be collected at the time of check in.

Office visit **Co-Pays, Co-insurance and or Deductibles are due prior to rendering services** at the check in window. Payment arrangements must be made prior to your appointment. Balances due on your account will be collected in advance before seeing the doctor.

Missed/No Show appointments and /or failure to cancel your appointment within 48 hours will result in a $40.00 fee. Stress Echo or any test scheduled, missed fee $75.00.

Prescription Refills require 5 business days advance notification. Please ensure you have enough medication before you run out. Call your Pharmacy and have them fax the request to our office.

Mail in Prescriptions require 10 days advance notice.

Medical Records fee is $35.00 please allow 5 business days to process your request.

We do not accept Secure Horizon - NTSP Group plan.

It is **your responsibility** to notify our office of any changes in your personal information: address, phone number, or insurance prior to your appointment.

We accept Cash, Checks, Money Orders, Debit Cards, Visa, MasterCard, Discover, Amex. $35.00 on all returned checks.

_____ _____

Patient Signature **Date**

Ellahi Heart Clinic

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY

Atif Sohail M.D. F.A.C.C.

400 W. Arbrook Blvd. Ste 220, Arlington, TX 76014
Phone: 817-419-7220 Fax: 817-419-7222

Interventional Cardiology
Cardiovascular Diseases

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized with in the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and /or as requested by you. We may other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and the request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Please Print:

I, _____ Date: ____/_____/_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Ellahi Heart Clinic

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY

Atif Sohail M.D. F.A.C.C.

400 W. Arbrook Blvd. Ste 220, Arlington, TX 76014
Phone: 817-419-7220 Fax: 817-419-7222

Interventional Cardiology
Cardiovascular Diseases

PATIENT CONSENT

Patient Consent for purposes of Treatment, Payment and Healthcare Operations: By signing this form, I consent to the use or disclosure of my protected health information by Ellahi Heart Clinic, P.A. for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct Ellahi Heart Clinic, health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Ellahi Heart Clinic, P.A. has taken action in reliance on my prior consent. I certify that I have received a copy of Ellahi Heart Clinic, P.A. Notice of Privacy Practices.

Release of Medical Information: I authorize release of any and all medical records, related Medical Information and billing information regarding my treatment for the purposes of substantiating insurance coverage and medical payment owed to this facility for all or part of the charges involving my care or the care of my family member for treatment. This authorization includes but is not limited to hospital or medical service companies, insurance Companies, worker's compensation carriers, or welfare funds.

I authorize any holder of medical information about me to release to the Social Security Administration, or its intermediaries, or the Medicaid agency, or its intermediaries, any information needed for the processing of a Medicare or Medicaid claim.

I also authorize other healthcare providers and facilities that have provided examination, diagnosis and/or treatment to me, or my family member, to release any and all medical records and related information regarding my diagnosis and treatment, to or by other healthcare providers for the purposes stated above.

I agree and consent to the release of any and all of aid records and medical information by oral, written, or electronic means of communication, to or from this facility to the parties stated above. Ellahi Heart Clinic, P.A. will not be responsible for the loss of, miscommunication or retrieval of, or confirmation of any electronically transmitted or non-certified correspondence to or from this facility.

I certify that I have read these Financial Policies and Consent Procedures and understand and agree to be personally and fully responsible for payment.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

Ellahi Heart Clinic

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION ECHOCARDIOGRAPHY

Atif Sohail M.D. F.A.C.C.

400 W. Arbrook Blvd. Ste 220, Arlington, TX 76014
Phone: 817-419-7220 Fax: 817-419-7222

Interventional Cardiology
Cardiovascular Diseases

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____
REFERRED BY: _____ **TODAY'S DATE:** _____

1. **What is the main reason you are seeing the doctor today?**
2. **Do you now have or have you had in the past, any of the following conditions:**

_____Heart Attack	_____High Blood Pressure
_____Diabetes Mellitus	_____ Stroke
_____High Cholesterol	_____ High Triglycerides
_____ Blocked Arteries	_____ Cancer (any kind)
_____ Ulcers	_____ Kidney or Bladder/Prostrate Problems

_____ Rheumatic Fever/ Rheumatic Heart Disease
_____ Lung Disease (asthma/Bronchitis/Emphysema/Other)

3. **Do you have now or have you had in the past, any other significant medical illnesses? Please describe briefly and give approximate date. (Include allergies, anemia, artheritis, bleeding problems, epilepsy, gallbladder disease, glaucoma, gout, mental problems, migraine headaches, TB)**

_____
_____
_____

4. **Please list any <u>Cardiovascular Surgeries</u> you have had. Also state (if known) the approximate date of surgery, the name of the physician or surgeon and name of hospital where performed.**

_____
_____
_____

5. **Please list any other surgeries you have had at any time:**

_____
_____
_____

6. **List any significant accidents or injuries which required medical treatment:** _____
_____
_____

7. **Allergies: Please list any <u>drugs or foods</u> you cannot tolerate due to allergy or adverse reaction:** _____
_____
_____

_____

8. **MEDICATIONS:**
Please list all prescription medications which you take regularly

_____
_____
_____

Please list any over-the-counter medications that you take regularly

_____
_____
_____

9. **Social History** (Circle Yes or No)
   A. **Do you smoke? YES OR NO Did you previously smoke? YES OR NO # of packs___ a week**
   B. **Do you use alcoholic beverages? YES OR NO if yes what is your typical intake: (Example: # of beers/week, oz. per day)** _____
   C. **What is your usual occupation?** _____

10. **Family History: Please list each family member, state whether living or deceased. List age at the time of death (if deceased). List known illnesses and /or cause of death.**

Family Member (Circle one)		Age	Illness/Cause of Death
Mother	Living/Deceased	___	_____
Father	Living/Deceased	___	_____
Brothers:	Living/Deceased	___	_____
	Living/Deceased	___	_____
	Living/Deceased	___	_____
	Living/Deceased	___	_____
Sisters:	Living/Deceased	___	_____
	Living/Deceased	___	_____
	Living/Deceased	___	_____
	Living/Deceased	___	_____
Children:	Living/Deceased	___	_____
	Living/Deceased	___	_____

11. **Have you previously had any of the following diagnostic test? If so, Please indicate approximate date, name of physician, and hospital/clinic where performed.**

Exercise Treadmill Test (Stress EKG Test) _____

Holter Monitor(24 hour EKG) or Event Recorder _____

Nuclear Studies of the heart (these test involve taking pictures of the heart after receiving a radioactive injection). Most commonly used tests are : Adenosine Cardiolite Test and Cardiolite Stress Test. _____

Cardiac Catherization (test in which dye is injected directly into the coronary arteries of the heart
_____

Coronary Angioplasty (Balloon procedure) _____

12. **Have you previously been under the care of another cardiologist? Please state name and address if known.** _____

Ellahi Heart Clinic

ICAEL
Accredited Echocardiography Laboratory

Atif Sohail M.D. F.A.C.C.
Board Certified Interventional Cardiology
and Cardiovascular Diseases

Main Office: 400 W. Arbrook Blvd, Ste 220 Arlington, TX 76014
Satellite Office:
Phone: 817-419-7220 Fax: 817-419-7222

Medical Records Request

Date _____

ATTN: _____

CLINIC: _____ **PHYSICIAN:** _____

PH: _____ **Fax:** _____

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

Patient Name: _____

Maiden Name/Alias: _____

Patient's Birth Date: _____ **Last 4 of SS No.** XXX-XX-_____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON : (X) Continued Medical Care ( ) Legal Purposes
( ) Insurance Purposes ( ) Personal Interest ( ) Other (Specify)_____

( ) Discharge Summary ( ) Emergency Room ( ) Laboratory Results ( ) History & Physical ( ) Progress Notes
( ) Diagnostic Test Results ( ) X-Ray Report ( ) Operative Reports ( ) Nurses Notes

( ) Radiology Film/Imaging/CD-ROM ( ) ENTIRE Records

Date of service or date ranges requested including month and year: _____

THE ABOVE RECORD IS TO BE RELEASED VIA FAX at 817-419-7222 TO THE FOLLOWING:

Name & Title: ELLAHI HEART CLINIC / ATIF SOHIAL, M.D.

Street Address: 400 W.Arbrook Blvd, Ste 220 **City/State/Zip:** Arlington TX 76014

Phone Number: 817-419-7220 **FAX:** 817-419-7222

Patient Signature _____ **Date** _____

I herby authorize you to provide a copy, summary, or narrative of my medical records (as indicated above) to Ellahi Heart Clinic.

_____ _____
Patient, Parent or Legally Authorized Representative **Date**

Relationship to the Patient: _____ **Social Security Number** _____

Phone Number _____

This consent will expire 1 year after the date above.

Ellahi Heart Clinic

Check In DATE: _____ Time Arrived: _____ A.M. / P.M.

AME: _____ Primary Tel#: _____ Alternate Tel#: _____

DDRESS: _____ APT# _____ CITY: _____ ST: _____ ZIP _____

Who is your Primary care Dr. _____ Name of Referring Dr. _____
First Name Last First Name Last

1. DOES YOUR INSURANCE PLAN REQUIRE PCP REFERRAL: ❑ YES NO ❑

2. DO YOU HAVE A REFERRAL FOR TODAY'S OFFICE VISIT? ❑ YES NO ❑

3. Do you have NEW INSURANCE: YES ❑ NO ❑ SAME: ❑

PRIMARY INSURANCE: _____ POLICY/ID# _____ COPAY $ ___

SECONDARY INSURANCE: _____ POLICY/ID# _____

is your responsibility to provide us with your most current insurance information. **~GIVE INSURANCE CARD & Photo ID to FRONT DESK**

I voluntarily authorize Ellahi Heart Clinic / Atif Sohail, M.D. to electronically transmit prescriptions to the pharmacy of my choice: review pharmacy benefit information and medication dispense history as long as I am a patient in this office or until I withdraw my consent in writing.

Patient Signature: _____ Date: _____ Guardian Signature: _____

Pharmacy Name: _____ Pharmacy Tel: _____ Fax: _____

Pharmacy Address: City: Near Intersection:

Please Circle Drug & Strength Allergies to Medications: YES or NO: Please Indicate:

Beta Blockers:
Betapace (*Sotalol*) = 80mg, 120mg, 160mg, 240mg
Toprol XL (*Metoprol Succinate*) = 25mg, 50mg, 100mg, 200mg
Bystolic (Nebivolol) = 2.5mg, 5mg, 10mg,
Lopressor (*Metoprolol Tartrate*) = 50mg, 100mg
Coreg (*Carvedilol*) = 3.125mg, 6.25mg, 12.5mg, 25mg
Coreg CR = 10mg, 20mg, 40mg, 80mg
Inderal (*Propranolol*) =10mg, 20mg, 40mg, 60mg, 80mg
Zebeta (*Bisoprolol*) = 5mg, 10mg
Sectral (Acebutolol) = 200mg, 400mg
Atenolol (Tenormin) = 25mg, 50mg, 100mg
Trandate (*Labetalol*) = 100mg, 200mg, 300mg

Calcium Antagonists:
Plendil (*Felodipine*) = 2.5mg, 5mg, 10mg
Cardizem SR/CD, Dilacor XR, Tiazac (*Diltiazem*) = 120mg, 180mg, 240mg, 300mg, 360mg, 420mg
Calan SR (*Verapamil*) = 40mg, 80mg, 120mg
Tarka (Trandolapril/Verapamil ER) = 2/180mg, 1/240mg, 2/240mg, 4/240mg
Norvasc (*Amlodipine*) = 2.5mg, 5mg, 10mg
DynaCirc (Isradipine) = 2.5mg, 5mg
DynaCirc CR = 5mg, 10mg
Sular (Nisoldipine) = 10mg, 20mg, 30mg, 40mg
Procardia XL (*Nifedipine*) = 10mg, 20mg
Exforge (Amlodipine/Valsartan) = 5/160mg, 10/160mg, 5/320mg, 10/320mg

ACE inhibitors:
Vasotec (*Enalapril*) = 2.5mg, 5mg, 10mg, 20mg
Lotensin (*Benazepril*) = 5mg, 10mg, 20mg, 40mg
Monopril (*Fosinopril*) = 10mg, 20mg, 40mg
Capoten (*Captopril*) = 12.5mg, 25mg, 50mg, 100mg
Zestril, Prinivil (*Lisinopril*) = 5mg, 10mg, 20mg
Mavik (*Trandolapril*) = 1mg, 2mg, 4mg
Accupril (*Quinapril*) = 5mg, 10mg, 20mg, 40mg
Altace (*Ramipril*) = 1.25mg, 2.5mg, 5mg, 10mg

Angiotensin II receptor Blockers:
Cozaar (Losartan) = 25mg, 50mg, 100mg
Diovan (Losartan potassium) = 40mg, 80mg, 160mg, 320mg
Avapro (Irbesartan) = 75mg, 150mg, 300mg

Diuretics:
Lasix (*Furosemide*)=20mg, 40mg, 80mg
Maxzide (Triam/HCTZ)= 37.5/25mg, 75/50mg
Hydrochlorothiazide= 12.5 mg, 25mg, 50mg

	Medication	Strength (mg)	Directions / Special Notes
1.			
2.			
3.			
4.			
5.			
6.			
7.			