ALABAMA CARDIOLOGY

SADISIVIA R. KATTA, M.D, F.A.C.C.
4700 Whitesburg Drive, Suite 200
Huntsville, AL 35802
Phone: (256)882-1450

NEW PATIENT INFORMATION (PLEASE READ CAREFULLY. PRINT & COMPLETE IN FULL)

PATIENT'S NAME IN FULL (NO NICKNAMES)	MARITAL S M W D SEP	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NO.
ADDRESS	CITY & STATE				ZIP CODE
HOME TELEPHONE NO.	CELL PHONE NO.				
OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?			BUSINESS PHONE NO. ( )
EMPLOYERS ADDRESS (STREET, CITY, STATE, ZIP)					
HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN			
EMPLOYER OF ABOVE NAME	OCCUPATION	PHONE ( )			
NAME AND ADDRESS OF PERSON TO NOTIFY IN CASE OF EMERGENCY		PHONE ( )			
REFERRED BY	ADDRESS, CITY, STATE, ZIP	PHONE			
FAMILY DOCTOR (IF DIFFERENT THAN ABOVE)	ADDRESS, CITY, STATE, ZIP	PHONE			
HAVE YOU HAD XRAYS, CT SCAN, ETC. FOR PROBLEM OR INJURY BEING SEEN FOR TODAY? WHEN AND WHERE? ☐ YES ☐ NO					

INSURANCE INFORMATION

PRIMARY INSURANCE CO.		DOES YOUR INSURANCE REQUIRE PRIOR AUTHORIZATION FOR TREATMENT? ☐ YES ☐ NO
NAME OF POLICY HOLDER	DATE OF BIRTH	PHONE NUMBER TO CALL FOR AUTHORIZATION
GROUP NO.	POLICY NUMBER	
ADDRESS OF INSURANCE COMPANY		
SECONDARY INSURANCE COMPANY		
NAME OF POLICY HOLDER	DATE OF BIRTH	
GROUP NO.	ID NO./CERTIFICATE NO.	
ADDRESS OF INSURANCE COMPANY		

AUTOMOBILE ACCIDENT	OTHER ACCIDENT? SPECIFY:	DATE OF ACCIDENT	NAME OF ATTORNEY

PLEASE READ THE FOLLOWING: ALL BILLS ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. ANY OTHER ARRANGEMENTS MUST BE MADE IN ADVANCE; INSURANCE IS FILED AS A COURTESY.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE PHYSICIAN/SUPPLIER FOR SERVICES DESCRIBED.

SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE _____ DATE _____

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BOARD CERTIFIED IN CARDIOLOGY, NUCLEAR CARDIOLOGY, ECHOCARDIOGRAPHY AND INTERVENTIONAL CARDIOLOGY

4700 WHITESBURG DRIVE, SUITE 200
HUNTSVILLE, ALABAMA 35802
PHONE: (256) 882-1450
FAX: (256) 882-3823

We at Alabama Cardiology are happy to fill out insurance forms for all of our patients as well as written prescriptions. All of this paper work takes time for us to complete when we are not seeing patients. Below you will find a list of fees for and time schedules for the above services.

PRESCRIPTIONS WILL BE CALLED IN WITHIN 24-48 HOURS. PLEASE CALL YOUR PHARMACY TO SEE IF IT IS READY.

We will need the patient's name, date of birth and the name and phone number of the pharmacy. Also needed is the name of the drug to be refilled, the dosage, and how often it is taken.

If you require insurance forms of any sort to be completed other than your medical insurance please note the following.

1. If it is necessary to obtain a copy of your Echocardiogram there will be a fee for copying it to tape or cd's. This fee is $40.00.
2. If you need a copy of the pictures from your stress test the fee is $12.50.
3. Disability forms will be $15.00 each pre-paid. It will take 7-10 working days for these form(s) to be completed. If medical records are required there will be an additional charge as follows $5.00 search fee plus $1.00 for each additional page. Please make sure you have your portion of the form completed with a phone number to call when the form(s) are ready.

_____

Patient Signature

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions for the use or disclosure of my health information:

_____

Name & Relation of friend or family member to whom your medical information may be discussed:

_____

Signature of Patient or Legal Representative Witness

Signature_____ Date: _____

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AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Alabama Cardiology and the release of information necessary to file insurance. I understand that co-pays, co-ins deductibles are due at time of service and I am financially responsible for any balance not covered by my insurance carrier. I understand that if my account is sent to collections, I agree to pay any associated collection fees. Authorization is continuing while patient is under care of Alabama Cardiology.

_____

Name (Print) Date

_____

Signature

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Cell Phone and Email Communication Consent

By providing any telephone number via any oral or written method at any time to Alabama Cardiology or by contacting us or our contractors or agents, from any phone number or email address, you authorize Alabama Cardiology, our clients, agents, and/or contractors to use any or all information, including cellular telephone numbers, for the purpose of contacting you regarding this account and any prior or subsequent accounts. This authorization is also expressly conveyed to any contractor, agent, third party, individual or others authorized by Alabama Cardiology or its providers, to assist with the resolution or collection of any indebtedness to any party for any reason. You acknowledge this contract may occur via automated dialing and messaging equipment, text messages, leaving messages on answering machines/voicemail or similar devices or methods, and includes leaving messages with individuals. You acknowledge and understand this authorization is not a condition of receiving healthcare treatment or services. This authorization shall remain in effect until individually withdrawn by you in writing to Alabama Cardiology and/or any others to which authorization has been extended.

_____ Date

Name: Print

_____

Signature

Risk Factors: Coronary Artery Disease

O High Blood Pressure
O Diabetes
O Smoking
O High Cholesterol
O Family history of Coronary Artery Disease
O Peripheral Vascular Disease

Medications: List Medications, Dose and instruction that you are currently taking

_____

_____

_____

_____

_____

_____

_____

Allergies: to medications or substances

_____

_____

_____

_____

Email address:_____

Do you have an advanced healthcare directive?

If no pulse/heart rate in our office, would you like us to perform CPR? __YES, ___NO, DON'T RESUCIATE

If yes, do you have someone to make medical decisions for you? ___YES (SDM) ___NO (NDM)

OFFICE STAFF INITIALS_____

PRINT NAME: _____DATE OF BIRTH: _____

PATIENT SIGNATURE: _____DATE: _____

W PATIENT HEALTH INFORMATION F M

General/Constitutional

Change in appetite	O Yes	O No
Chills	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Headache	O Yes	O No
Lightheadedness	O Yes	O No
Sleep disturbance	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No

ENT

Difficulty swallowing	O Yes	O No
Nosebleed	O Yes	O No
Ringing in the ears	O Yes	O No
Sinus pain	O Yes	O No
Sore throat	O Yes	O No

Endocrine

Cold intolerance	O Yes	O No
Excessive sweating	O Yes	O No
Excessive thirst	O Yes	O No
Frequent urination	O Yes	O No
Hair loss	O Yes	O No
Heat intolerance	O Yes	O No
Weakness	O Yes	O No

Respiratory

Chest pain with breathing	O Yes	O No
Cough	O Yes	O No
Coughing up blood	O Yes	O No
Shortness of breath at rest	O Yes	O No
Shortness of breath with exertion	O Yes	O No
Sputum production	O Yes	O No
Wheezing	O Yes	O No

Cardiovascular

Chest pain at rest	O Yes	O No
Chest pain with exertion	O Yes	O No
Difficulty lying flat	O Yes	O No
Dizziness	O Yes	O No
Fluid accumulation in the legs	O Yes	O No
Orthopnea	O Yes	O No
Palpitations	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No
Blood in stool	O Yes	O No
Change in bowel habits	O Yes	O No
Constipation	O Yes	O No
Decreased appetite	O Yes	O No
Diarrhea	O Yes	O No
Heartburn	O Yes	O No
Hematemesis (vomiting blood)	O Yes	O No
Nausea	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No
Recent transfusion	O Yes	O No
Swollen glands	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No
Pain in lower back	O Yes	O No
Painful urination	O Yes	O No

Musculoskeletal

Joint stiffness	O Yes	O No
Leg cramps	O Yes	O No
Muscle aches	O Yes	O No
Painful joints	O Yes	O No

Peripheral Vascular

Cold extremities	O Yes	O No
Pain/cramping in legs after exertion	O Yes	O No
Ulceration of feet	O Yes	O No

Skin

Blistering of skin	O Yes	O No
Discoloration	O Yes	O No
Rash	O Yes	O No
Sun sensitivity	O Yes	O No

Neurologic

Memory loss	O Yes	O No
Seizures	O Yes	O No
Tingling/Numbness	O Yes	O No
Transient loss of vision	O Yes	O No
Tremor	O Yes	O No

PRINT NAME: _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____