CENTRIC HEART & VASCULAR
2103 Silva Lane, Moberly, MO 65270
Ph: 660-616-0022 Fax: 660-530-4565

Date Filled Out:_____

Patient Name:_____ Date of Birth:_____ Sex: M or F

SSN:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Care Physician:_____

Pharmacy:_____ Phone:_____

I authorize Centric Heart and Vascular to release my protected health information to the following people on my behalf:

Name: Relationship: Phone #:

_____

_____

_____

_____

Social & Family History:

1. Marital Status: Single Married Domestic Partner Separated Divorced Widowed
   Lives: Alone (with) Spouse Domestic Partner Family Member
2. Children: ☐ Yes ☐ No Number of Children:_____
3. Tobacco Usage? ☐ Yes ☐ No ☐ Former If yes or former: Year stopped:_____ Year started smoking?_____
   How many packs per day?_____
4. Alcohol: ☐ Yes ☐ No If yes, how often? Frequently Daily Social Rarely Former: Year Quit_____
5. Diet: (please circle) Regular Diabetic Low Salt Weight Loss
6. Caffeine: ☐ Yes ☐ No If yes, (circle all that apply): >2 Servings Daily <2 Servings Daily
   i. Type: Chocolate Coffee Tea Soda Energy Drinks
7. Drug use/Abuse: ☐ Yes ☐ No ☐ Former
8. Occupation: _____

Family History of Heart & Vascular	**Yes/No**	**If yes, describe**
Mother	Yes / No	_____
Father	Yes / No	_____
Brother	Yes / No	_____
Sister	Yes / No	_____

Reason for visit:_____

_____

Previous Medical Conditions: **Date:**

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

Previous Surgeries: ☐ **None** **Date:**

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

Medications: ☐ **None** **Dosage & Frequency:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: ☐ **None** **Reaction:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

CENTRIC
HEART & VASCULAR
2103 Silva Lane, Moberly, MO 65270
Ph: 660-616-0022 Fax: 660-530-4565

Records Request

I, the undersigned patient or legal representative, hereby authorize Centric Heart and Vascular, LLC to request any health information, including the diagnosis and records of any treatment or examination rendered to me.

Patient Name:_____ Date of Birth:_____

This Information may be disclosed to and used by the following:

Centric Heart and Vascular, LLC
2103 Silva Lane
Moberly, MO 65270
Ph: 660-616-0022 Fax: 660-530-4565

Please obtain records from:_____

Date(s) of Service:_____ Records Requested:_____

Please obtain records from:_____

Date(s) of Service:_____ Records Requested:_____

Please obtain records from:_____

Date(s) of Service:_____ Records Requested:_____

This request is for the purpose of treatment, payment, and/or Health care operations.

This authorization will be valid while I am a current patient with Centric Heart and Vascular, LLC. I understand that I may revoke this authorization at any time by notifying Centric Heart and Vascular, LLC in writing, but if I do, it will not have any effect on the actions that Centric Heart and Vascular, LLC took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

I authorize Centric Heart and Vascular, LLC to contact my device company to switch home monitoring and other services from my previous physician.

_____ _____

Patient Signature/ Patient Representative Signature and Relationship Date

Patient Name:_____ Date of Birth:_____

FINANCIAL RESPONSIBILITY

I have requested medical services from Centric Heart and Vascular on behalf of myself and/or my dependents, and understand that by making this request, I am financially responsible for ALL CHARGES incurred in the course of the treatment. This is not a free Clinic and the responsibly party WILL BE RESPONSIBLE for what the insurance will not cover on treatment by CENTRIC HEART AND VASCULAR.

ASSIGNMENT OF INSURANCE/MEDICARE/MEDICAID BENEFITS

I hereby assign all insurance benefits to include major medical benefits to which I am entitled to CENTRIC HEART AND VASCULAR. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and other health/ medical plans, to issue payment directly to CENTRIC HEART AND VASCULAR for medical services provided to myself and/or dependents. I understand that I am responsible for any amount not covered by insurance including deductibles, copays, other services or items not covered by my insurance plan(s).

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Centric Heart and Vascular to (1) release/retrieve any relevant information necessary to insurance carriers regarding my illness and treatments, (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.

HIPPA - PRIVACY POLICY AT CENTRIC HEART AND VASCULAR

I have been provided a copy of Centric Heart and Vascular privacy policy and have been given the right to read it in full before signing this form. A photocopy of these assignments and authorization and my signature below is to be considered as valid as the original.

CONSENT FOR MEDICAL TREATMENT

I hereby request services and treatment from the CENTIRC HEART AND VASCULAR. I understand that no guarantees have been made concerning the results or effectiveness of the prescribed treatment plan (including any prescribed medication). The risk and side effects of the treatment plan (including any prescribed medication) have been explained to me. I understand I am to notify my medical provider, emergency room or county health department of any difficulties that may arise. I hereby request that a person authorized by CENTRIC HEART AND VASCULAR examine and treat me, and a suitable drug, device, or method be prescribed, fitted or inserted.

I authorize any hold of medical or other information about me to release the same to the Social Security Administration and Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carrier, the minimum necessary information needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to insurance or Medicare assignment of benefits apply. I attest that the insurance information that I am providing is true and accurate. If this information is found to be false, I will be responsible for payment or all services rendered.

I also authorize that transfer of my Protected Health Information (PHI) to others for the purposes of “treatment” to be “electronically” transmitted on my behalf, including but not limited to fax, mail, e-mail, or via computer database.

If you must cancel an appointment with our office, we ask that you notify us 24-48 hours in advance.

I also acknowledge that I have been provided the Notice of Privacy Practices, as well as the Patient Responsibility and Accountability Contract. I further acknowledge that I am responsible to uphold all Centric Policies. This signed receipt will become a permanent part of my medical record.

The doctor-patient relationship is based on trust and open communication. In order for your physician to make valid diagnosis and render beneficial care, the information you provide the him/her must be complete and true.

Eligibility criteria for acceptance in this program are administered on a nondiscriminatory basis regardless of race, color, national origin, age, sex, religion, genetic information or disability.

_____ _____

Patient/ Patient Representative Signature Date