VASCULAR HEART & LUNG ASSOCIATES
Hani Shennib, MD, MSc, FRCSC, FACS / Richard R. Heuser, MD, FACC, FACP, FESC, MSCAI
3850 E Baseline Road, Building 1, Suite 103 • Mesa, AZ 85206
Phone: 480 722 7589 • Fax 480 857 8313

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I: _____

Address: _____City:_____ State: _____ ZIP: _____

Telephone (cell): _____ (home): _____

Email: _____

Check preferred contact method:
☐ Cell phone ☐ Home phone
☐ Email ☐ Mail
☐ Work phone

Date of Birth (MM/DD/YEAR): _____/_____/_____ Age: _____ Sex: _____

Leave voicemail? ☐ YES ☐ NO

Ethnicity [circle]: Hispanic/Latino / Not Hispanic/Latino Language [circle]: English / Spanish Other: _____
Race [circle]: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White
Relationship to Guarantor [circle]: Self / Spouse / Child / Other: _____
Marital Status**:** S M W D Spouse's Name: _____
Employed? Full-time / Part-time Employer: _____ Not Employed Retired Student

Family Doctor: _____ Phone/Fax: _____
Referred by: _____ Phone/Fax: _____
Cardiologist/Kidney Doctor/Other: _____ Phone/Fax: _____
Pharmacy: _____ Phone/Fax/Crossroads: _____

If you would like any person(s) to be able to communicate with Vascular, Heart & Lung about your care, please include their name below. You may add or subtract any person at any time. You may discuss and organize my care with the following person(s):

Name: _____ Name: _____
Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

INSURANCE INFORMATION

Please bring your insurance cards with you to every visit and **provide the following information if other than self:**

Primary Insurance Company: _____
Policy Holder Name: _____Date of Birth: _____/_____/_____ Sex: _____
Employer: _____Patient's Relationship To Policy Holder: _____

Secondary Insurance Company: _____
Policy Holder Name: _____Date of Birth: _____/_____/_____ Sex: _____
Employer: _____Patient's Relationship To Policy Holder: _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby give permission to treat me, or my dependents, as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of medical information necessary for filing health insurance claim forms for me by Hani Shennib, MD and Vascular Heart & Lung Associates to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

Signature:	**Date:**

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NOTICE and ACKNOWLEDGEMENT OF PRIVACY PRACTICES ("HIPAA")

I acknowledge that I have received and reviewed the Notice of Privacy Practices for Vascular Heart & Lung Associates. I understand that I may refuse to sign this acknowledgement.

Patient Signature or Personal Representative Signature:	**Date:**

CANCELLATION POLICY

We realize you may need to change your appointment; however, we require a 24-hour notification of cancellation for appointments so we may offer your time to another patient. If you fail to cancel, $40 will be added to your patient account for the scheduled time, $100 for a ultrasound cancellation and, $250 for nuclear or cath procedure cancellation.

MEDICAL RECORDS RELEASE POLICY

We require an medical records release request form be filled out and signed in order to release personal copies of medical records. **Once we have received the request form, please allow 7-10 business days for processing**.

INSURANCE/MEDICARE PAYMENTS

"I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I also authorize the above-named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related insurance/Medicare claim."

FINANCIAL POLICY and PATIENT'S RESPONSIBILITY

- **To know their insurance policy**. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- **To obtain a referral from their Primary Care Physician (PCP)** and /or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- **To pay their co-pay at the time of service**.
- **To pay any insurance/Medicare deductible and co-insurance amounts not covered by their supplemental insurance**.
- **To promptly pay any patient responsibility indicated by their insurance carrier**. A late charge of 1.5% per month (or 18% per annum) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- To facilitate any claims payment by contacting their insurance carrier when claims have not been paid.
- A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

FINANCIAL POLICY ACKNOWLEDGEMENT

I have read and understood the above policies, release of medical information and assignment of benefits; I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check, MasterCard or Visa. I agree that if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

Patient Name (please print):	**Signature:**	**Date:**

RESEARCH CONSENT

Your medical chart may be reviewed by Vascular, Heart & Lung personnel for the purpose of determining eligibility for specific research trials. Please indicate by checking YES or NO whether you agree to be contacted by our staff to discuss your possible interest in participating in a research study: ☐ YES ☐ NO

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TELEPHONE CONSUMER PROTECTION ACT ("TCPA")

We are soon enabling patient appointment reminders and messaging via SMS mobile texting or voice telephone calls in addition to the email reminders currently in use. This is an optional service and requires your express written consent.

By signing below, I consent to receive calls and/or text messages from Hani Shennib, MD ("Dr. Shennib") and Vascular Heart & Lung Associates ("VHL") for my protected healthcare and other services on the following phone number:

Cell phone number:

I understand I may be charged for such calls and texts by my wireless carrier and that such calls and texts may generated by an automated dialing system.

I understand I may revoke this authorization to receive further calls or messages at any time. Such revocation does not have to be in writing.

Patient Name (please print):	**Signature:**	**Date:**