

**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): \_\_\_\_\_ Check preferred contact method:

Cell phone  Home phone

Email: \_\_\_\_\_  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.

<b>Signature:</b>  	<b>Date:</b>  
---------------------------	----------------------

**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

**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.

<b>Patient Signature or Personal Representative Signature:</b>	<b>Date:</b>
--	--------------

**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.

<b>Patient Name (please print):</b>	<b>Signature:</b>	<b>Date:</b>
-------------------------------------	-------------------	--------------

**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

**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

---

**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:

<b>Cell phone number:</b>
---------------------------

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.

<b>Patient Name (please print):</b>	<b>Signature:</b>	<b>Date:</b>
-------------------------------------	-------------------	--------------

**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 HISTORY**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation: \_\_\_\_\_ Retired: YES or NO Marital Status: S M W D  
Referring Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Reason for Visit:** What cardiac, thoracic or vascular problems do you have? \_\_\_\_\_

**PERSONAL HISTORY and RISK FACTORS**

Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Heart Attack (myocardial infarction)	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Cancer - What type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Bleeding Tendencies	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Heart Valve Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Other Major Illness: _____		

**SURGICAL HISTORY**

Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	What Procedures? _____
Vascular Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	What Procedures? _____
Cardiovascular Procedures/Intervention	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	What Procedures? _____

**OTHER SURGERIES**

Type: _____	When? _____	Type: _____	When? _____
Type: _____	When? _____	Type: _____	When? _____

**FEMALES ONLY**

Have you had a total Hysterectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you gone through menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking hormone replacements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SOCIAL HABITS - do you?**

Use Tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Much? _____	When did you quit? _____
Drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Much? _____	When did you quit? _____
Drink Caffeine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Much? _____	When did you quit? _____
Take Illicit Drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Much? _____	When did you quit? _____

List any problems with mobility or self-care: \_\_\_\_\_



**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 HEALTH CHECKLIST - Check only the problems you frequently experience or have been treated for in the past.**

**Constitutional**

- Significant weight change
- Night Sweats
- Unexplained Fever

**Eyes**

- Cataracts
- Blurred or double Vision
- Glaucoma

**ENMT**

- Difficulty swallowing
- Dry, hoarse throat

**Cardiovascular**

- Chest discomfort
- Fluttering feeling in chest
- Skipped Heartbeats
- Swelling in ankles/feet

**Respiratory**

- Wheezing
- Chronic cough
- Asthma
- History of Tuberculosis
- Shortness of breath

**Gastrointestinal**

- Indigestion
- Ulcers

**Genitourinary**

- Loss of bladder control
- Blood in urine

**Musculoskeletal**

- Arthritis
- Back Pain
- Muscle weakness

**Integumentary**

- Skin Rash

**Neurological**

- Headache
- Memory Loss
- Stroke
- Speech problems

**Psychological**

- Depression
- Anxiety
- Unusual stress
- Eating disorder

**Endocrine**

- Thyroid problems

**Hematology/Lymphatic**

- Breast masses/lumps
- Unexplained bruising

**Allergic/Immunologic**

- Drug allergies
- Mold, pollen, dust allergies

**Other**

\_\_\_\_\_  
\_\_\_\_\_

**Comments:**

---

I have filled out my personal medical history and my family history to the best of my abilities. Please remember to always bring an updated medication list to your office visits.

<b>Patient Signature:</b>  	<b>Date:</b>  
-----------------------------------	----------------------