VASCULAR HEART & LUNG ASSOCIATES
Hani Shennib, MD, MSc, FRCSC, FACS
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: _____

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

Check preferred contact method:
☐ Cell phone ☐ Home phone
☐ Email ☐ Mail
☐ Work phone
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 Vascular Heart & Lung Associates and Hani Shennib, MD 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 (available w/ front office in hard copy or online at: https://www.vascularheartandlung.com/uploads/1/2/0/6/12064949/privacy_practices.pdf) 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.

MEDICAL RECORDS RELEASE POLICY

We require a 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 Signature or Personal Representative Signature:	**Date:**

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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 Vascular Heart & Lung Associates ("VHL") and Hani Shennib, MD ("Dr. Shennib") / Richard Heuser, MD ("Dr. Heuser") / Katie Harjes, NP 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:**

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

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

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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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

Have you ever experience or have been diagnosed with:

Congestive Heart Failure	☐ Yes	☐ No	When? _____
Heart Attack (myocardial infarction)	☐ Yes	☐ No	When? _____
High Blood Pressure	☐ Yes	☐ No	When? _____
Diabetes	☐ Yes	☐ No	When? _____
Stroke	☐ Yes	☐ No	When? _____
High Cholesterol	☐ Yes	☐ No	When? _____
Cancer – What type: _____	☐ Yes	☐ No	When? _____
Lung Disease	☐ Yes	☐ No	When? _____
Kidney Problems	☐ Yes	☐ No	When? _____
Bleeding Tendencies	☐ Yes	☐ No	When? _____
Thyroid Disorder	☐ Yes	☐ No	When? _____
Peripheral Vascular Disease	☐ Yes	☐ No	When? _____
Heart Valve Disease	☐ Yes	☐ No	When? _____

Other Major Illness: _____

SURGICAL HISTORY

Heart Surgery	☐ Yes	☐ No	When? _____	What Procedures? _____
Vascular Surgery	☐ Yes	☐ No	When? _____	What Procedures? _____
Cardiovascular Procedures/Intervention	☐ Yes	☐ No	When? _____	What Procedures? _____

OTHER SURGERIES

Type: _____When? _____ Type: _____When? _____
Type: _____When? _____ Type: _____When? _____

FEMALES ONLY

Have you had a total Hysterectomy?	☐ Yes	☐ No	Do you take birth control pills?	☐ Yes	☐ No
Have you gone through menopause?	☐ Yes	☐ No	Are you taking hormone replacements?	☐ Yes	☐ No

SOCIAL HABITS – do you?

Use Tobacco?	☐ Yes	☐ No	How Much? _____	When did you quit? _____
Drink Alcohol?	☐ Yes	☐ No	How Much? _____	When did you quit? _____
Drink Caffeine?	☐ Yes	☐ No	How Much? _____	When did you quit? _____
Take Illicit Drugs?	☐ Yes	☐ No	How Much? _____	When did you quit? _____

List any problems with mobility or self-care:

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FAMILY HISTORY and RISK FACTORS

Mother: Alive: ☐ Yes ☐ No Age: _____ or Age Deceased: _____
Major Health problems: _____

Father: Alive: ☐Yes ☐No Age: _____ or Age Deceased: _____
Major Health problems: _____

Brothers: Alive: ☐Yes ☐No Age: _____ or Age Deceased: _____
Major Health problems: _____

Sisters: Alive: ☐Yes ☐No Age: _____ or Age Deceased: _____
Major Health problems: _____

Children: Alive: ☐Yes ☐No Age: _____ or Age Deceased: _____
Major Health problems: _____

Have any blood relatives died suddenly? ☐Yes ☐No Age: ____ Relation: _____

ALLERGIES or intolerance to MEDICATIONS? ☐Yes ☐No If yes, specify medication(s): _____
_____
Reaction(s): _____

OTHER ALLERGIES (food, adhesive tape, x-ray contrast dye, latex, etc) ☐Yes ☐No
If yes, specify what: _____
Reaction: _____

CURRENT MEDICATIONS - Please provide an updated list of your medications at each office visit (we will copy your list).

DRUG	DOSAGE (mg)	HOW MANY TIMES PER DAY?

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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.

Patient Signature:	**Date:**

Revised 09/2023