NEVADA CARDIOLOGY ASSOCIATES

BOARD CERTIFIED CARDIOLOGISTS

Foad Moazez, MD, FACC, FCCP
Samuel E. Green, MD, FACC
Patrick C. Hsu, MD, FACC
Robert L. Baker, MD, FACC
Richard Chen, MD, FACC
Navid Kazemi, MD, FACC
Vanessa G. Gastwirth, MD, FACC
Erik Sirulnick, MD, FACC
Tariq Marroush, MD, FACC
Carmel Moazez, MD

Today's date:	Primary Care Dr:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home Phone.:	Cell phone: ( )

Apt Number:	City:	State:	ZIP Code:

Occupation:	Employer:	Work Phone & ext: ( )

Race:	Ethnicity (choose one) ❑ Hispanic or Latino ❑ Not Hispanic	Language:

Ok to leave detailed message? ❑ Yes ❑ No	Email Address:	Do you have an advanced directive? Such as:

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:	Policy No:	Group no:

Subscriber's name:	Subscriber's Social Security no:	Date of Birth: / /

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

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SECONDARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:	Policy No:	Group no:
Subscriber's name:	Subscriber's Social Security no:	Date of Birth: / /

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PHARMACY INFORMATION

Preferred Local Pharmacy:	Phone:	Fax:	Address:
Mail Order Pharmacy:	Phone:	Fax:	Address:

RELEASE OF INFORMATION

I give permission to release my medical information to the following:

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nevada Cardiology Associates to release any information that we have acquired, that is necessary to process my claims. I allow Nevada Cardiology Associates permission to view prescription history from external sources. I allow Nevada Cardiology Associates to obtain my results/records from radiology facilities, laboratory facilities, hospital facilities and any other medical providers.

Patient/Guardian signature *Date*

NEVADA CARDIOLOGY ASSOCIATES
PATIENT/PRACTICE AGREEMENT

Patient Name: _____

I consent to medically necessary evaluation and treatment.

I authorize direct or fax release of all medical records to my referring physician and insurance company and/ or companies.

I acknowledge my full financial responsibility for services rendered by Nevada Cardiology Associates. I understand that payment for charges incurred is due at the time of service. I agree to pay all reasonable attorney fees and collection costs, in the event I default on payment for my charges. I also understand that if I do not provide payment, when due, that I will not be allowed to continue in the practice.

I acknowledge that Nevada Cardiology Associates will bill my insurance company, as a courtesy, for services rendered. I additionally understand that my contract for services is with Nevada Cardiology Associates directly, and not the insurance company. After 90 days, or if insurance payment is denied, I understand that I will assume responsibility for all charges incurred. A service charge of 1.5% per month of the current unpaid balance may be charged on all accounts exceeding 90 days. I also understand that a fee of $25.00 will be charged to me for any returned check, or invalid credit card transaction.

I understand that it is my responsibility to provide accurate insurance information, and to immediately report any changes in my insurance coverage. I also understand that it is my responsibility to determine whether Nevada Cardiology Associates, or any other medical facilities are providers for my insurance plan.

I understand that I may have to be rescheduled if I am 10 minutes late for my appointment. Scheduled appointment times are generally adhered to, but no guarantee is implied. Unforeseen events may cause rescheduling or cancellation of your appointment. I also understand that if I need to cancel or reschedule an appointment or procedure, I must contact the office at least 24 hours prior to the appointment.

Nevada Cardiology Associates limits its scope of practice to cardiovascular diseases. Hence, it is my responsibility to pursue general health care, and cancer screening measures outside of this practice, as needed. If I do not have a primary care physician, Nevada Cardiology Associates will make recommendations, upon my request. I additionally understand that it is my responsibility to contact Nevada Cardiology Associates, regarding any necessary adjustments to my medications, based on laboratory testing. I understand that I must review my prescription drugs prior to office visits, and request any prescription refills at the time of the office visit.

I understand that I will not be allowed to continue in the practice, if I repeatedly miss appointments or procedures, or fail to follow recommended medical treatment.

_____ _____

Signature Date

HIPAA Notice of Privacy Practices

Nevada Cardiology Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Department of Motor Vehicles, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We reserve the right to change the terms of this notice at any time and the new notice will be available upon request. You then have the right to object or withdraw as provided in this notice.

This notice becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____

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MEDICAL RELEASE OF INFORMATION

I hereby authorize NEVADA CARDIOLOGY ASSOCIATES to release and/or discuss my medical records, which may include my diagnosis, treatment plan, prognosis, office notes and documents, hospital visits, imaging or laboratory results, as well as all personal and social information to be compliant with HIPAA Law, to the below named individuals.

_____

_____

_____

_____

_____
Patient Name (Please Print)

_____
Signature

_____
Date of Birth

_____
Today's Date

5380 S. Rainbow Blvd., Suite 308, Las Vegas, Nevada 89118 • (702) 463-8988 • Fax (725) 205-3077
3201 S. Maryland Pkwy., Suite 400, Las Vegas, Nevada 89109 • (702) 796-7150 • Fax (702) 796-9071
3150 N. Tenaya Way, Suite 460, Las Vegas, Nevada 89128 • (702) 233-1000 • Fax (702) 233-1001
Visit Us Online at: NevadaCardiology.com @NevadaCardiologyAssociates @nvheartdocs

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Medical Records Release

____ **I wish** to participate in electronic health exchanges, hospitals, healthcare facilities and clinics to release and obtain my medical records to and from Nevada Cardiology Associates.

____ **I DO NOT wish** to participate in electronic health exchanges, hospitals, healthcare facilities and clinics to release and obtain my medical records to and from Nevada Cardiology Associates.

_____

Patient signature

_____

Patient Name (Print)

_____

Patient DOB

_____

Today's Date

_____

NCA Contact

3201 S Maryland Parkway, Ste 400, Las Vegas, Nevada 89109 (702)796-7150 Fax (702)796-9071
3150 N Tenaya Way, Ste 460, Las Vegas, Nevada 89128 (702)233-1000 Fax (702)233-1001
5380 S. Rainbow Blvd., Ste 308, Las Vegas, Nevada 89118 (702)463-8988 Fax (725)205-3077
www.nevadacardiology.com