NEW PATIENT INFORMATION

Heartland CARDIOLOGY LLC

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Peeyush Grover, M.D. Ryan Beard, M.D.

Date: _____

Dear: _____

You are scheduled for an appointment with:

Dr. _____

Location: **3535 N. Webb Road, Wichita, KS 67226**
Phone: Heartland Cardiology: 316-686-5300

***Date:** _____ **Time:** _____

1. Please complete the enclosed forms and bring them with you to your appointment.

2. Please bring your insurance card(s) AND photo ID to your appointment.

3. **Bring all medications you are currently taking, in the bottles.**

4. **It is very important that we have your past pertinent medical records.** Please verify that these records are being mailed or faxed to our office from your referring physician's office prior to your appointment. This allows our physician to review your records prior to your appointment.

5. If you are a member of a managed health plan such as Coventry HMO/POS, AETNA, CIGNA, TriCare, or UHC Compass, you will need to obtain a written referral from your primary care physician. You may verify in advance that your referring physician's office is taking care of any necessary referrals. If you have any questions, please contact our office for assistance.

6. **If you are a member of any insurance plan that requires a written referral and you do not obtain authorization from your primary care physician prior to your visit, you will be responsible for all charges at this appointment.**

PLEASE ARRIVE 15 MINUTES EARLY FOR YOUR APPOINTMENT

Last Name:_____

First Name:_____ Middle Initial:_____

Address:_____

City:_____ St:____ Zip:_____

Primary Phone:(____)_____ Alternate :(____)_____

Work Phone:(____)_____

Place of Employment:_____

Primary Care Doctor:_____

Referring Doctor:_____

Are you currently seen by another Cardiologist? Yes/ No

If yes, please provide name:_____

DOB:____/_____/_____ Social Security Number:_____-_____-_____

Marital Status: Married Single Divorced Widowed

Race/Ethnic Group: ___ American Indian/Alaskan ___ Asian/Pacific Islander

___ Black/African American ___Caucasian/White ___ Hispanic ___ Other

Primary Insurance:_____SecondaryInsurance:_____

Policyholder's Name:_____ Policyholder's Name:_____

Emergency Contact:_____ Phone: (_____)_____-_____

Relationship:_____

Pharmacy:_____Address:_____

Patient Name: _____

Reason for today's visit:_____

Medications (Name, Dose, How Often) Please list heart-related medications first:

1._____ 6._____
2. _____ 7._____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10._____

Medical History: Please circle all that apply

High Blood Pressure / Heart Attack / Stroke / High Cholesterol / Diabetes / Coronary Artery Disease

Palpitations / Dizziness / Shortness of Breath / Irregular Heartbeat / Leg Swelling / Leg Pain

Other Medical History:_____

Allergies/Intolerances:_____

Surgical History

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Family History (Please check all boxes that apply)

Family Member	Living?	Age	Heart Attack	Hypertension	Diabetes	CVA	Mental Illness	Cancer	Ventricular Dysfunction
Father									
Mother									
Sibling									
Sibling									

Social History

Alcohol Consumption: YES / NO How much/How Often:_____
Recreational Drug Use: YES / NO Drug name/How Often:_____
Caffeine: YES / NO Type/Amount/How Often:_____
Marital Status: Married Single Divorced Widowed
Occupation:_____
Exercise: YES / NO Type/How Often:_____
Smoker: YES / NO/ Former Type/How long:_____ Interested in Quitting? YES / NO
* FORMER Smoker: How much did you smoke?:_____How long ago did you quit?:_____

Other Medical Conditions Not Listed Above:

_____

_____

Patient Name: _____ Date of Birth: _____

Do you have any of the following symptoms?

YES NO Chest pain

YES NO Shortness of Breath
Mild Activity Moderate Activity Severe Activity

YES NO Dizziness

YES NO Palpitations

YES NO Swelling in legs/feet

YES NO Leg cramps
Mild Activity Moderate Activity Severe Activity

Do you lay flat to sleep? YES / NO

How many pillows do you use at night? _____

Do you wake up at night gasping for air? YES/NO

Energy Level GOOD/ FAIR/ POOR

Do you have any cardiac concerns? YES / NO If yes, please explain

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Heartland Cardiology, LLC
3535 N. Webb Road, Wichita, KS 67226 [316-686-5300]
9000 W. Central Avenue, Wichita, KS 67212
215 S. Pine St., Suite 301, Newton, KS 67114
1719 E. Cambridge, Suite 101, Derby, KS 67037

PAYMENT POLICY

Methods of payment include Cash, Check or Credit Card. We accept Visa, Master Card and Discover. We are also able to take payments on account over the phone via credit card.

INSURANCE ***Insurance cards are required at every visit.***
We participate in most insurance plans as a courtesy to our patients. We will file a claim with your insurance carrier(s). If you are not insured by a plan we do business with, or you do not have your current insurance card with you, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to deductible, co-payments, co-insurance and non-covered charges.

MOTOR VEHICLE ACCIDENTS AND PERSONAL LIABILITY ACCIDENTS
If you receive treatment as a result of a vehicle accident or other liability accident, Heartland Cardiology will hold you personally responsible for your bills. Since cases may require many months to resolve, Heartland Cardiology cannot wait for final decisions.

COVERAGE/ADDRESS/PHONE NUMBER CHANGES
It is your responsibility to inform us of any changes in your coverage, address, phone number or employment status.

CO-PAYMENTS
Co-payments are due before you are seen by the provider. This is a contractual requirement dictated by your insurance. Co-pays are to be paid at every visit and will not be billed.

FORMS COMPLETION
Base fee for completion of forms, which the provider and/or staff are requested to complete, will be $25.00. This fee may be increased based on the time spent completing the form. You may be required to see the physician before this form is filled out. This may include, but is not limited to, the following forms: Family Medical Leave, Disability, prior authorization of medications, etc.

PAYMENT ARRANGEMENTS (All payment arrangements are subject to approval)
Payment for services not covered by insurance is required to be paid in full at the time of service. Payment arrangements will not typically be approved for office visits, which need to be paid at the time of service. If you need to set up payment arrangements on other services, it will be set up the following way:

- 90-day Plan: The balance is divided by three equal payments to be paid for three consecutive months. This will need to be set up by one of our Patient Account Team Members. Please visit with the Business Office and they will be happy to assist you.

We are unable to hold accounts for extended periods of time. However, if you are unable to pay off your balance in 90 days, you may contact our Patient Accounts Team who can review other possible options with you. Once an acceptable arrangement is agreed upon in writing, it will not be renegotiated. Failure to pay as agreed upon will void the agreement and the account may be turned over to collections.

An account is considered delinquent when:

a. No payment arrangements have been made within 30 days of final insurance payments.
b. There is no response to phone calls and/or letters.
c. Terms of established arrangements are not met.

CONTACT RELEASE INFORMATION

My signature below indicates my agreement to permit Heartland Cardiology and our business associates to contact me, and all other responsible parties on my account, on my cell phone or other mobile device concerning any and all aspects of my account.

HEALTH SAVINGS ACCOUNT (HSA) HIGH DEDUCTIBLE ACCOUNTS ($1,000 OR ABOVE)

If you have a Health Savings Account (HSA), please visit with a member of our Patient Accounts Team and we can discuss your account with you, based on your individual benefits.

RETURNED CHECKS

The charge for a returned check is $30.00, payable in cash, money order or credit card.

MINOR CHILDREN

The parent(s) or guardian(s) who bring the minor to the office is responsible for the co-pay, or balance due after insurance. We will not become involved in disputes between parents and guardians.

ACKNOWLEDGEMENT

I have read and understand the payment policy and agree to abide by its guidelines. I understand that I may be given a copy of these guidelines, at any time, upon request. I further understand that failure to make payment on a balance will indicate that I have chosen to voluntarily withdraw myself, and any immediate family members, from the care of Heartland Cardiology.

_____ _____

Signature of Patient or Responsible Party Date Signed

_____

Print Patient Name

_____

Date of Birth

Rev. 1/22

PATIENT PORTAL INFORMED CONSENT

Patient Name: _____ DOB: _____

Email Address: _____

As a service to our patients, Heartland Cardiology offers secure viewing of portions of your medical record and communication with our staff through our Patient Portal. Secure messaging can be a valuable communications tool but does have certain risks. In order to manage these risks we need to impose some conditions of participation, and confirm that you accept the risks and agree to the conditions of participation. This service is optional and not required to communicate with our clinic.

HOW THE SECURE PATIENT PORTAL WORKS

A secure Web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading attachments, communications or information. Secure messages and information can only be read by someone who knows the right password to log into the portal site***. THE PORTAL SHOULD NEVER BE USED IN AN EMERGENCY SITUATION.***

HOW TO PARTICIPATE IN OUR PATIENT PORTAL

You can compose, retrieve and reply to secure messages or view information sent to you through our website: www.heartlandcardiology.com. Once you have read and signed this form, you will be sent an e-mail notification that gives you instructions to register for the first time. This notification will give you the URL (internet address) of the website to log in using the username and temporary password provided. You will then be prompted to create your own password. Once this step is completed, you can read/ view information on your computer, look in your message box to see any new or old messages, or view other parts of your electronic medical record. The information is encrypted in transmission between the website and your computer. Additional clinic specific information is available through our website. Emails to staff should be through this portal, otherwise they are NOT secure.

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors:

- The secure message must reach the correct e-mail address
- Only the correct individual, or someone authorized by that individual, must be able to get access to it

Only YOU can make sure these two factors are present. You need to make sure we have your correct e-mail address, and we are informed if it ever changes. Please also keep track of who has access to your e-mail account; so that only you, or someone you authorize, can see the messages you receive from us.

It is your responsibility to keep unauthorized individuals from learning your password. If you think someone has accessed your password, you should promptly go to the website and change it. If you experience problems, contact our IT department at 316-686-5300. We understand the importance of privacy in regard to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including e-mail addresses, without your written consent.

CONDITIONS OF PARTICIPATING IN THE PATIENT PORTAL

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service you will be notified as promptly as possible. By signing this document and agreeing to "Opt-In", you agree not to hold Heartland Cardiology or any of its staff liable for any reason.

_____ Opt-In **_____ Opt-Out**

_____ _____

Signature Date

PLEASE READ THE FOLLOWING INFORMATION AND SIGN THIS AUTHORIZATION TO HELP US WITH FILING YOUR INSURANCE

I hereby authorize Heartland Cardiology to release any information relating to all claims for benefits submitted on behalf of me and/or dependent(s) to any appropriate insurance carrier(s). I agree that my signature on this document authorizes my physician to submit claims for services rendered or for services to be rendered, without obtaining my signature on each claim submitted. I hereby assign to Heartland Cardiology and all providers therein, all payments of this authorization and assignment shall be considered as valid as the original until it is revoked.

MEDIGAP ASSIGNMENT OF BENEFITS (MEDICARE PATIENTS ONLY)

I hereby authorize Heartland Cardiology to release any information relating to all claims for benefits submitted on behalf of me to Medigap/secondary insurance company. I hereby assign Heartland Cardiology and all providers therein all payments for medical services rendered to me until it is revoked.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Heartland Cardiology Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive Heartland Cardiology Notice of Privacy Practices, effective 4/14/03, revised 2/01/13, revised 5/1/15.

RECORDING OF OFFICE VISITS IS PROHIBITED

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices. Thank you for your understanding and compliance.

_____ _____

Signature of Patient or Patient Representative Date Signed