Champion
Heart & Vascular
Center, PA

www.championheartandvascularcenter.com
Phone: 910-304-1212

PATIENT INFORMATION

Date: _____ ☐ New Patient ☐ Update

Patient: _____ ☐ Male ☐ Female
Last First MI Title

Patient Date of Birth: _____ Patient SSN: _____

Address: _____ Home: _____

_____ Cell: _____

City _____ State ____ Zip ____-____

Email: _____

Referral? ☐ Yes ☐ No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Phone: _____
Name Relationship

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____ Office: _____

_____ Direct: _____

City _____ State ____ Zip _____

INSURANCE INFORMATION

Subscriber: _____
Last First MI Title

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY INSURANCE CARRIER: _____

Group Policy No.: _____ ID No.: _____

Address: _____ Phone: _____

_____ Toll-free: _____

City _____ State ____ Zip _____ Fax: _____

SECONDARY INSURANCE CARRIER: _____

Group Policy No.: _____ ID No.: _____

Address: _____ Phone: _____

_____ Toll-free: _____

City _____ State ____ Zip _____ Fax: _____

PATIENT CONSENT - PAYMENT AUTHORIZATION - SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the Champion Heart & Vascular Center, P.A. and staff at the next appointment without fail.

I hereby authorize payment directly to Champion Heart & Vascular Center, P.A. of the medical benefits otherwise payable to me.

I hereby authorize Champion Heart & Vascular Center, P.A. to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering medical claims and/or discussing treatment options with other medical professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

_____ _____

Patient's Signature or Signature of Patient's Representative | Date of Signature

_____ _____

Patient's or Patient's Representative Name | Relationship

_____

Date of Birth of Person Signing The Form

FINANCIAL AGREEMENT

Champion Heart & Vascular Center, P.A. will file insurance for all reimbursable services, to both your company and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays and non-covered service amounts.

I authorize my insurance benefits to be paid directly to Champion Heart & Vascular Center, P.A.

I authorize Champion Heart & Vascular Center, P.A. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient's Signature: _____

Print Patient's Name: _____

Date: _____

Prescription History Consent

I voluntarily consent to provide Champion Heart & Vascular Center, P.A. access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which included but is not limited to prescriptions, labs, and other health care drug historical information) form multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Champion Heart & Vascular Center, P.A. may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect for one year of service received from Champion Heart & Vascular Center, P.A. unless revoked by me in writing.

I certify that I have read this form or it has been read to me.

Date: _____ **Print Name (Patient):** _____

DOB: _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that Champion Heart & Vascular Center, P.A. Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Champion Heart & Vascular Center, P.A. cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge I have received a paper copy of the Champion Heart & Vascular Center, P.A. Notice of Privacy Practices. _____ **(Patient's Initials)**

Champion
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____(Facility name) to disclose any and all protected health information of the patient identified below to:

Champion Heart & Vascular Center, P.A.

The purpose of this disclosure is for my continued treatment.

The protected health information to be released is to be released with no limitations.

I understand that the information disclosed pursuant to this authorization may be subjected to re-disclosure and may no longer be protected by the federal privacy regulations promulgated pursuant to the health insurance portability and accountability act (HIPPA).

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire one (1) year from the date signed below unless revoked earlier. I understand that I may revoke this authorization by notifying, in writing, _____(facility name) except to the extent that _____(facility name) has taken action in reliance on this authorization.

I understand that signing this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits. I have a right to receive a copy of this authorization.

I am willing that a photocopy or facsimile of this authorization be accepted with the same authority as the original.

Signature: _____Date of signature:_____

Patient name: _____

Date of birth: _____

Champion
Heart & Vascular
Center, PA

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

To be completed by Patient or Patient's Representative

I, _____ have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

I _____ (Name) give consent for Champion Heart & Vascular Center, P.A. to speak with _____(Name) in regards to my payment options for patient responsibility. My relationship with this person is _____.

_____ Today's Date: _____
Patient's Signature or Signature of Patient's Representative

_____ Relationship: _____
Print Name of Patient or Patient's Representative

Our Privacy Officer can be contacted as follows:
Name of Privacy Officer:
Practice Address:
Practice Phone: Practice Fax:

This form does not constitute legal advice and covers only federal, not state laws.

Champion
Heart & Vascular
Center, PA

NO SHOW/MISSED APPOINTMENT POLICY

We, at (Champion Heart & Vascular Center, PA), understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 910-304-1212.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at (PRACTICE NAME) and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

3. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. (Champion Heart & Vascular Center, PA) will assist you to reschedule this appointment if needed.

4. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $50.00 no show fee.

5. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $50 no show fee assessment. Dismissal from the practice will be considered.

   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Champion Heart & Vascular Center, PA No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

Champion
Heart & Vascular
Center, PA

Procedure Cancellation Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Champion Heart & Vascular Center, PA reserves the rights to charge a fee $250.00 for the missed procedure, and procedures which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

Cancellation fee will be billed to the patient, and no other/future appointments will be scheduled until this fee is paid completely (NO EXCEPTIONS). This fee is not covered by insurance. Failure to comply with this policy may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Print Name **Date**

_____

Signature/Responsible Party

NOTICE OF PRIVACY PRACTICES

Purpose: A federal law, known as the "HIPPA Privacy Rule," requires that we explain how we use and release health information about you. This form presents the information that federal law required us to give our patients regarding our privacy practices. Please review it carefully. The privacy of your health information is important to us. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use or disclose your information to obtain payment for services we provided to you.
- **Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.
- **To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make a reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- **Marketing Health-Related Services:** We will not use your health information for marketing communication without your prior authorization.
- **Required By Law:** We may use or disclose your health information when we are required to do so by law.

- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voice-mail messages, postcards, or letters).

PATIENT RIGHTS

- **Access:** You have the right to look at or get a copy of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. (You must make a request in writing to obtain access to your health information.) You must obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
- **Disclosure and Accounting:** You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions.
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means you request.
- **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
- **Questions and Complaints:** If you are concerned that we have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure, or to have us communicate with you by alternative locations, you may complain to us using the contact information listed below, or you can submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Tammy Ausby
Email: manager@championheartandvascular.com
Address: 721 Tilghman Drive, Suite 400
Dunn, NC 28334
Phone: 910-304-1212
Fax: 910-292-2627

Champion Heart & Vascular Center, PA

Patient Name: _____

Procedure(s): _____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by North Carolina Law, and not by a lawsuit or resort to court process except as North Carolina Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2: I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatments or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to a claim. This includes, but Is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement. as set forth in.the CMA/CHA Medical Arbitration Rules.

3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THE AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

5: I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE PARAGRAPH 1 OF THIS CONTRACT.

_____ _____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient) Date

If signed by other than patient, indicate relationship:

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Paragraph 4 above.

_____ _____

(Physician or Duly-Authorized Representative) Date

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.