PIMA HEART

...where every heart beat counts

www.pimaheart.com

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Mary L. Ruehl, M.S., N.P.
David Strout, N.P.
Deborah J. Tanner, M.S., N.P.
Regina Wright, M.S., N.P.

Your Primary Care Team

Athar A. Shaikh, M.D.
Sanjaya Hebbar, M.D.
Harvey Maksvytis, M.D.

Pima Heart Imaging Center
2404 E. River Rd., Bldg. 2, Ste. 100
Tucson, AZ 85718

520-696-4780 • Fax 520-690-3911
Toll Free 888-504-3278

Dear Patient:

We are glad that you have chosen Pima Heart for your healthcare needs. Please take some time to fill out the enclosed forms. The Patient Registration and Medical Information Forms contain information vital to allowing us to provide complete medical care and to ensure proper insurance coverage.

You must bring the completed forms on your first visit. It is also important that you bring a driver license or picture identification on your first visit. Please bring your insurance cards on every visit, in case we need to update your information for correct billing to your insurance company.

If your insurance plan requires a referral for specialty care, please obtain a referral from your primary care physician. You must bring your referral with you. Copayment is due at time of service. Additionally, if you have had an EKG, lab work, or other diagnostic testing such as an echocardiogram, etc., please bring a copy of these records with you as well. Bring all medications or an updated list of medications. Your referring physician should be able to provide you with copies.

If you have any questions, please contact the staff office member at the office number listed below. We look forward to providing you with the highest quality of healthcare available.

If you are unable to keep your appointment, please notify us 24 hours prior.

Sincerely,
The Physicians and Staff of Pima Heart

Central Scheduling: (520) 838-3540

POS Reorder # 9800825

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REGISTRACIÓN DE PACIENTE

PATIENT REGISTRATION

(TO BE FILLED IN COMPLETELY - PLEASE PRINT)

Información del Paciente

PATIENT INFORMATION

Nombre Completo
FULL NAME _____ Fecha de nacimiento DATE OF BIRTH_____ / ____ / _____ Edad AGE_____

Direccion Local
LOCAL ADDRESS _____ APT/SP _____ Circle One Hombre/Mujer **Male/Female** Marital Status **S M W D** Esposo(a) **Spouse**_____

Ciudad
CITY _____ Estado STATE_____ Colonia ZIP CODE _____ Teléfono de casa HOME PHONE _____

Visitante de invierno
WINTER VISITOR Yes ___ No ___ Direccion Permanente PERMANENT ADDRESS_____ APT/SP _____

Ciudad
CITY _____ Estado STATE_____ Colonia ZIP CODE _____ Teléfono de casa HOME PHONE_____ Teléfono celular CELL PHONE _____

No. de seguro social
SOCIAL SECURITY NO. _____ No. de licencio de manejar DRIVER'S LICENSE NO. _____ Estado STATE_____

Patrón
EMPLOYER _____ Direccion ADDRESS _____ Teléfono de negocio BUSINESS PHONE _____

If retired, please state company _____

Contacto emergencia
EMERGENCY CONTACT_____ Relacion RELATIONSHIP _____

Camino
STREET _____ Ciudad CITY _____ Estado STATE_____ Colonia ZIP _____ Teléfono PHONE _____

Recomendado por quien
REFERRED BY _____
Nombre NAME Teléfono PHONE

Correo electrónico
EMAIL ADDRESS _____

RACE:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ More than one Race
- ☐ Other Race
- ☐ Unknown/Not Reported
- ☐ White

ETHNICITY:
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Unknown/Not Reported

Persona responsible

RESPONSIBLE PARTY

Preferred Language _____

Nombre completo
FULL NAME _____ Relacion RELATIONSHIP _____ No. de seguro social SOCIAL SECURITY NO. _____

Direccion
ADDRESS _____ Fecha de nacimiento DATE OF BIRTH_____ / ____ / _____

Ciudad
CITY_____ Estado STATE _____ Colonia ZIP CODE _____ Teléfono de casa HOME PHONE _____

Patrón
EMPLOYER_____ Teléfono de negocio BUSINESS TELEPHONE_____

Direccion
ADDRESS_____ Colonia ZIP CODE _____

Información de seguro médico

MEDICAL INSURANCE INFORMATION

Primera aseguranza
PRIMARY INSURANCE CARRIER _____ HMO OR PPO? Si YES_____ No NO_____ Paga en parte CO PAYMENT? $ _____

Direccion
ADDRESS _____ Ciudad CITY _____ Estado STATE _____ Colonia ZIP_____

No. de grupo
GROUP NO. _____ Identificacion o no. de poliza ID OR POLICY NO. _____

Posesor or de poliza
NAME OF POLICY HOLDER _____ Relacion a paciente RELATIONSHIP TO PATIENT _____

Segunda aseguranza
SECONDARY INSURANCE CARRIER _____

Direccion
ADDRESS _____ Ciudad CITY _____ Estado STATE _____ Colonia ZIP_____

No. de grupo
GROUP NO. _____ Identificacion o no. de poliza ID OR POLICY NO. _____

Posesor de poliza
NAME OF POLICY HOLDER _____ Relacion a paciente RELATIONSHIP TO PATIENT _____

AUTORIZACIÓN PARA DAR INFORMACIÓN MEDICA, DESIGNACIÓN DE BENEFICIOS Y PAGOS DE CUENTA.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS & PAYMENT OF ACCOUNT

I authorize Pima Heart Physicians, P.C. to release medical information for insurance purposes concerning treatment of the above patient while under their care. I assign my rights to benefits of insurance plans to Pima Heart Physicians, P.C., and I agree to pay any fees not covered by insurance. If collections proceedings are required, I agree to pay reasonable collection fees. I also authorize my hospital records be released to Pima Heart Physicians, P.C.

Yo autorizo a las oficinas de Pima Heart Physicians, P.C. que den informacion sobre los datos medicos de mi, mientras estoy bajo el cargo de la clinica, con el objetivo de verificar el tratamiento medico para la seguranza. Al firmar este dato, yo entiendo que todos los beneficios y derechos de mi propio plan de seguranza se aplicaran con Pima Heart Physicians, P.C., y tambien entiendo que soy responsible de cuentas delicuentes, no pagadas por mi seguranza. Si es necesario que una agencia de colecciones se utilise yo estoy de acuerdo en pagar gastos de coleccion que sean razonables. Tambien autorizo a las oficinas de Pima Heart que obtengan datos medicos mios de otras clinicas y hospitales.

Signatura
SIGNATURE _____ Fecha DATE _____

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MEDICAL INFORMATION

Name: _____DOB _____Age_____Date: _____

What problem brought you to our office?_____
Who is your primary care physician? _____
Referred by_____Current Occupation _____
Do you have a Living Will? Yes_____ No_____

Medical History

1. High Blood Pressure Yes_____ No_____
2. Elevated Cholesterol/Triglycerides Yes_____ No_____
3. Smoking Yes_____ No_____ If yes, number of years_____ Packs per day _____
   Date you quit Smoking_____
4. Diabetes Yes_____ No_____
5. Family History (father, mother, sister, or brother with heart disease before age 65) Yes___No___

Exercise: Never_____ 1 - 2 times/wk._____ 3 or more times/wk_____
Any history of Drug or Alcohol Abuse? Yes_____ No_____ Drug Used_____
Alcoholic beverages: Number/day_____Number/wk_____
Caffeinated beverages: Number/day_____Number/wk_____

Current Medications and Dosages:

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

Do you have any Allergies to medications or foods? Yes____ No____ If yes, What medications or foods and reaction: _____
_____

List Hospitalizations below

	Reason for Hospitalization	Year	Hospital
1.			
2.			
3.			
4.			
5.			

List any other medical problems: _____
_____
_____
_____

Signature_____

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Patient Consent to Release Protected Health Information

Authorized by: Patient Legal Guardian/POA _____

The Physician/Practice may use or disclose the following protected health information:

Please check all that apply:

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only

The following protected health information is specifically exempt from disclosure (may not be shared):

Please check all that apply:

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only
- ☐ Other: _____

The purpose of the use/disclosure is:

Please circle all that apply:

- ☐ Continued medical care
- ☐ Employer's use
- ☐ Family/spouse's employer's use
- ☐ School use
- ☐ Other: _____

This authorization is in force until:

- ☐ One year
- ☐ It is revoked in writing

Disclosure to:

Spouse: _____

Children: _____

Others: _____

Okay to leave a voicemail at the following phone numbers: _____

_____ _____

Patient's Name (please print) DOB Date

_____ _____

Patient / Guardian Signature Relationship to patient

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how Health Information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable Health Information.

OUR COMMITMENT TO YOUR PRIVACY

Pima Heart is dedicated to maintaining the privacy of your individually identifiable Health Information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of Health Information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your Health Information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION IN THE FOLLOWING WAYS:

Treatment: We may use your Health Information to treat you. We may ask you to have laboratory tests to help us reach a diagnosis. We might use your Health Information to write a prescription, or we may disclose your Health Information to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including but not limited to, our physicians, nurses and staff, may use or disclose your Health Information in order to treat you or to assist others in your treatment.

Payment: We may use and disclose your Health Information in order to bill and collect payment for service you receive from us.

Health Care Operations: We may use and disclose your Health Information to operate our business. We may use your Health Information for operational purposes to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. The entities and individuals covered by this Notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatments Alternatives/Health-Related Benefits and Services: We may use and disclose your Health Information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your Health Information to others involved in your medical care or helps pay for your care, including but not limited to, your spouse, children, parents or friend.

Research: Under certain circumstances we may use and disclose your Health Information for research purposes. For example a research project may involve comparing the health and recovery of all patients who received one medication or treatment to those who received another, for the same condition. We may permit researchers to look at records to help them identify patients who may be included in the research projects.

As Required by Law: We will disclose your Health Information when required to do so by international, federal, state or local law.

To Avert Serious Threat to Health or Safety: We may use and disclose your Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help or prevent the threat.

Business Associates: We may disclose your Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All our business associates are obligated, under contract with us, to protect the privacy of your Health Information and are not allowed to use or disclose any Health Information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ or tissue donor, we may release your Health Information to organizations that handle organ procurement or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release your Health Information as required by military command authorities. We also may release your Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release your Health Information for workers' compensation or similar programs.

Public Health Risks: We may disclose your Health Information for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; prevent or control diseases, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products that they may be using; a person who may have been exposed to a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make such disclosure.

Health Oversight Activities: We may disclose your Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose your Health Information in response to a court or administrative order. We also may disclose your Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement: We may release your Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; about crime conducted on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities and Protective Services: We may release your Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Coroners, Medical Examiners and Funeral Directors: We may release your Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official. This release would be if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) the safety and security of the correctional institution.

Information with Additional Protections: Certain types of Health Information have additional protection under state and federal laws. For instance, Health Information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and court ordered mental evaluation is treated differently than other types of medical information. This Health Information requires your permission before disclosing to others in most circumstances.

Other Uses of Health Information: Other use and disclosures of your Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission, with some limitations; you have the right to revoke in writing.

YOU HAVE THE FOLLOWING RIGHTS REGARDING THE HEALTH INFORMATION WE MAINTAIN ABOUT YOU.

Right to Request Confidentiality Communication: You have the right to specify where you would like to be contacted.

Right to Request Restrictions: You have the right to request a restriction on our use of disclosure of your Health Information for purposes other than treatment, payment and business operational purposes. We will try to accommodate your request; however, granting restrictions is not always possible.

Right to Inspection and Copies: You have the right to review and request copies of your Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments: If you feel that your Health Information is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by Pima Heart. A request for amendments must be submitted in writing to the Privacy Officer.

Right to Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your Health Information. However, Health Information released in certain circumstances, such as for payment, treatment or operations will not be included in the list. The first list you request within a 12 month period will be free. For additional lists, we may charge you for providing the list.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may request a copy of this Notice at any time.

How to Exercise Your Rights: To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. Alternatively, to exercise your right to inspect and copy your Health Information, you may contact your physician's office directly.

Request Information or File a Complaint: If you have questions, would like additional information, want to report a problem regarding the handling of your Health Information or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact our Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services. We can not and will not require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our practice. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

How to Contact our Privacy Officer: Pima Heart Physicians, PC, Privacy Officer, 3375 N Campbell Ave, Tucson, AZ 85719

The terms of this notice apply to all records containing your Health Information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

I _____ have been given Pima Heart Physicians Notice of Privacy Practices. Signature _____ Date _____

(Print Patient Name & DOB) (Patient or legally authorized individual signature)

White Copy - Pima Heart Yellow Copy - Patient

Effective April 2003
Revised July 2011
POS® Reorder # 1117354

PIMA HEART
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Dear Valued Pima Heart Patient,

I am writing to request your participation in our secret patient experience feedback process. It is similar to a secret shopper program and we just want to know how your experience was with our practice. At Pima Heart we are committed to service and want to make sure you receive the best care and attention you deserve. Our staff, management and physicians are dedicated to ensuring you receive the best care possible. Attached are the questions we would like you to answer about your appointment with us. You will be looking for specific things like is the employee wearing a name badge, did s/he smile, help, and thank you. Please take an opportunity to review the form before your appointment. Please either send your responses to me in an email to Linda@pimaheart.com or send written answers to me at the address below. Your response is strictly confidential and your name is not included in any part of the tracked/shared responses unless you indicate we may share your information for training purposes. Employees who score very well and provide you with exceptional service are eligible for prizes so this survey is intended to recognize very good service or provide the necessary training to improve. Please let me know if you have any questions about this process and I certainly hope your experience with Pima Heart Physicians is a very good one.

Best Regards,

Linda Andrews

Linda Andrews
Executive Director
Pima Heart Physicians, PC
3709 N. Campbell Ave. Ste. 135, Tucson, AZ 85719
Phone: **this is not an appointment line (520) 838-2440 **
Fax: (520) 629-0111

If you have questions or need to make changes to your appointment, please call (520) 838-3540

Pima Heart Secret Shopper Patient Experience Form

Location/Address of Office:

_____

Check-in

1. Was the person who checked you in for your appointment wearing a name badge?
   Name:_____

   Did s/he acknowledge you, smile and make you feel welcome? Yes ❑ No ❑

   Was this person as helpful as you felt s/he should be? Yes ❑ No ❑

   Were you pleased with your check-in experience? Yes ❑ No ❑

Comments:_____
_____
_____

2. How long did you wait after checking in until seeing your provider? _____

Medical Assistant

3. Was the person who brought you back to the exam room wearing a name badge?
   Name:_____

   Did s/he acknowledge you, smile and make you feel welcome? Yes ❑ No ❑

   Was this person as helpful as you felt s/he should be? Yes ❑ No ❑

   Did s/he explain everything to you in a way you understood? Yes ❑ No ❑

   Were you pleased with your physician's medical assistant? Yes ❑ No ❑

Comments:_____
_____
_____

Physician

4. Which physician did you see at Pima Heart? _____

   Was your physician sensitive to your needs? Yes ❑ No ❑

   Did your physician give you an opportunity to ask questions? Yes ❑ No ❑

   Did your physician explain things to you using words you could understand? Yes ❑ No ❑

   Was your physician friendly and courteous? Yes ❑ No ❑

Would you recommend this care provider to others? Yes ❑ No ❑

Comments:_____

_____

_____

Check-out

5. Was the person who checked you out for your appointment wearing a name badge?

   Name:_____

   Did s/he acknowledge you, smile and make you feel welcome? Yes ❑ No ❑

   Was this person as helpful as you felt s/he should be? Yes ❑ No ❑

   Were you pleased with your check-out experience? Yes ❑ No ❑

Comments:_____

_____

_____

Overall Experience

6. Would you recommend Pima Heart to others? Yes ❑ No ❑

Please provide feedback on your overall experience at Pima Heart. We want to continually improve the service we provide our patients and your comments are essential in this endeavor. Thank you for your time.

_____

_____

_____

_____

_____

_____

_____

_____

May we share your name/ experience: Yes or No _____

**We need your name so we can look up the staff (in our system) who assisted you if they are not wearing a name badge at your appointment. Thank you so much for your feedback!

Patient Name: _____

Appointment Date:_____

Physician Seen:_____