Colorado Heart Clinic
A Division of Healthy Connections
Vito Calandro, M.D., FACC
10345 S. Parkglenn Way, Suite G-100 Parker, CO 80138
Phone: (303) 778-1171 Fax: (303) 778-1674

Patient Information

First Name_____MI_____Last Name_____
DOB_____Sex Male/Female Preferred Language: English/Other_____
Address_____
Home Phone_____Cell Phone_____
Work Phone_____Email_____
May we leave a message with results? (Please circle) YES/NO If yes, which phone? Home/Cell/Work
Primary Care Physician_____ Facility_____
Marital Status (please circle) Single / Married / Widowed / Divorced / Separated
Race (please circle) Decline / American Indian / Asian /African American / Hawaiian or Pacific Islander / White / Other
Ethnicity (please circle) Hispanic or Latino / Not Hispanic or Latino

Insurance Information

Does the patient have insurance? (Please circle) YES/NO
If no, please understand that the patient is considered self-pay and financially responsible for all treatment.
Policy Holder's Information (Guarantor) (please circle) Self /Other Employer_____
Name_____Date of Birth_____/_____/_____
Social Security Number_____Employer_____
Cell Phone_____Work Phone_____
Primary Insurance Company_____
Insurance Company Billing Address_____
Policy Number_____Group Number_____
Secondary Insurance Company_____
Insurance Company Billing Address_____
Policy Number_____Group Number_____

Emergency Contact Information

Name_____Relationship_____Number_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED TO PROCESS CLAIMS, UTILIZATION REVIEW AND QUALITY ASSURANCE FOR SERVICES RENDERED AND HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MY PHYSICIAN. INFORMATION THAT HAS BEEN PROVIDED THAT IS NOT CORRECT WILL RESULT IN BEING BILLED DIRECTLY.

Please carefully review all information, and ask any additional questions you may have. You may request a copy of this form at any time, or also find one online on the Heart Clinic of Colorado website.

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Medical History Form

Name_____DOB_____

Age_____Date_____Referring Physician_____

Reason for Visit_____

Current Medications

Name	Dose	Directions for use	Prescriber

Drug Allergies No Known Drug Allergies

Allergy	Reaction

Previous Hospitalizations/Surgeries

Date/Year	Reason for Admission/Surgery Type

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Do You...

Smoke Cigarettes? Yes/No

In the past, when did you stop?_____

And how many years did you smoke?_____

If you still smoke, how many per day?_____

And for how many years? _____

Drink Alcohol? Yes/No

If yes, how many drinks per week? _____

Drink caffeine? Yes/No

If yes, how many per day? _____

Take Herbal Supplements? Yes/No

If yes, please list below:

_____

_____

_____

Exercise Regularly? Yes/No

If so, what type and how often? _____

What is your cholesterol level?_____When was it last checked?_____

Family History

Relative	Living	Deceased	Age of Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sibling's	_____	_____	_____	_____
Sibling's	_____	_____	_____	_____
Sibling's	_____	_____	_____	_____
Sibling's	_____	_____	_____	_____

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Please check if you have ever had any of the following conditions?

Heart Attack_____ Rheumatic Fever_____ Heart Murmur_____

Irregular Heart Rhythm_____ Heart Catheterization (angiogram) _____

Lung Disease_____ Tuberculosis_____Thyroid Problems_____

Stomach Ulcers_____ Diabetes_____High Blood Pressure_____

Liver Disease_____ Kidney Disease_____Cancer_____

Please check if you have ever had any of the following symptoms in the past few months

Fever_____ Shaking Chills_____ Weight Change_____Appetite Change_____Changes in vision_____

Coughing up blood_____ Cough_____Wheezing_____ Bloody Stool_____Dark, tarry stool_____

Vomiting_____ Blood in urine_____ Painful urination_____Skin rashes_____Skin lesions_____

Sudden blindness_____ Seizures_____Dizziness_____ Fainting_____Crying spells_____

Easy bruising_____ Easy bleeding_____

The following questions pertain to your legs

Varicose Veins_____ Spider Veins_____Leg Ulcers_____ Swollen Legs_____Aching/Pains_____

Heaviness_____ Tiredness/Fatigue_____ Itching/Burning_____Swollen Ankles_____

Leg Cramps_____Restless Legs_____Throbbing_____

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Venous Health History Form

Patient Name: _____ Date: _____
DOB: _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery? □ Yes □ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? □ Yes □ No
   If yes, when and which leg? _____
3. Have you ever had a blood clot? □ Yes □ No
   If yes, when and which leg? _____
4. Have you ever had phlebitis? □ Yes □ No
   If yes, when and which leg? _____

Family History

Does anyone in your family have/used to have varicose veins, spider veins, leg ulcers or swollen legs?

Father	□ Yes	□ No
Mother	□ Yes	□ No
Brother(s)	□ Yes	□ No
Sister(s)	□ Yes	□ No
Other	□ Yes	□ No

Current History

1. Do you experience any of the following in your legs? If yes mark which leg.

Aching/pain?	□ Yes	□ No	□LT / RT leg	□Both legs
Heaviness?	□ Yes	□ No	□LT / RT leg	□Both legs
Tiredness/fatigue?	□ Yes	□ No	□LT / RT leg	□Both legs
Itching/burning?	□ Yes	□ No	□LT / RT leg	□Both legs
Swollen Ankles?	□ Yes	□ No	□LT / RT leg	□Both legs
Leg Cramps?	□ Yes	□ No	□LT / RT leg	□Both legs
Restless Legs?	□ Yes	□ No	□LT / RT leg	□Both legs
Throbbing?	□ Yes	□ No	□LT / RT leg	□Both legs

Other? _____

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2. Have your veins gotten worse in recent months? □ Yes □ No
   Describe: _____
3. Do you take any medication for pain (i.e. Advil or Motrin)? □ Yes □ No

If yes list medications taken, dosage, how many, how often: _____

4. Do you elevate your legs to relieve discomfort? □ Yes □ No
   If yes, how long per day do you elevate and does it provide relief? _____
5. Do you exercise? □ Yes □ No

If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? □ Yes □ No
   If yes, what type and gradient? How long have you worn them?
   _____
7. Do you wear light support hose (i.e. Sheer Energy)? □ Yes □ No

If yes, do they provide relief? □ Yes □ No

8. Do you have any problem walking? □ Yes □ No

If yes, describe how it interferes with your activities of daily living, which activities?

_____

9. What type of work do you do? _____

How long do you stand (hours per day) at work? _____ At home? _____

Describe how your symptoms are/if interfering with your essential job function of your specific occupation, which activities? _____

10. Have you ever had any test(s) done on your veins? □ Yes □ No

If yes, when and what type of test and where on the leg?

_____

11. Were you diagnosed with saphenous vein reflux? □ Yes □ No

Patient Signature: _____ Date: _____

PHYSICIAN TO COMPLETE REMAINDER

Initial Physician Evaluation

Date of Initial Physician Exam: _____ **Initials:** _____

Check all that apply:

□ Reviewed Venous History □ Physical examination of the affected leg(s) □ Edema severity test completed

□ Duplex or Doppler Scan order of the affected leg(s)

□ Graduated, elasticized compression stockings (30-40 mmHg), **prescribed by a physician not in our practice**, have been used by the patient for at least 90 days.

□ Prescribed for graduated, elasticized compression stockings given to patient.

□ Today □ given at an earlier date: _____ □ Length of time to be worn: _____

□ Standing photos taken of leg(s) □ Front □ Back □Front and Back

□ Clinical notes received from referring physician

□ Other Cases of patient's leg(s) symptoms have been ruled out

□ Instruction given on medication dosage □ Instruction given on daily leg evaluation

□ Instruction given for mild exercise □ Instruction given for weight reduction

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Patient Pharmacy Information

Please Note: In order to fulfill e-prescribe requirements, this form must be completed for any new or refill prescription requests. Without this information, we will not be able to fill your necessary prescriptions.

Please first contact your Pharmacy for refills of prescriptions prescribed by a HCC provider. Please allow 2 business days for the processing and approval of all prescriptions. Please keep in mind weekends and holidays may effect this time frame. Thank you for your cooperation.

Patient Name_____DOB_____Today's Date_____

Name of Local Pharmacy _____

Street Address (or cross-streets if unknown) _____

City_____Zip Code_____

Phone Number:_____Fax Number: _____

Name of Mail Order Pharmacy _____

Member Number (if applicable) _____

Phone Number:_____Fax Number: _____

If you do not have information for today's visit, please complete this form at home and either mail or fax it to our office. Thank you for your understanding.

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DESIGNATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND, OR LEGAL REPRESENTATIVE

I,_____, designate the following person(s) to be able to speak to a physician, physician assistant, or other staff member of Heart Clinic of Colorado, should it be necessary, on my behalf. I hereby give permission to Heart Clinic of Colorado through its physicians and staff to release to my designee(s) any information about my medical condition, medical needs, or the status of my account. I release Heart Clinic of Colorado, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person_____

Relationship_____ Phone: _____

Name of Designated Person_____

Relationship_____ Phone: _____

Patient's Printed Name _____

Patient Signature_____Date_____

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PATIENT AGREEMENT CONSENTS

CONSENT TO TREAT

I voluntarily consent to outpatient care involving routine diagnostic procedures, examination, and medical treatment including those procedures deemed medically appropriate by Heart Clinic of Colorado providers.

I authorize the clinic to release information to insurance carriers to process claims and authorize payment of medical benefits to the undersigned physician or supplier for services described below. I further authorize release of medical information to my medical providers or anyone I designate in writing, This Consent to Treatment remains in effect until I revoke my consent in writing.

HIPAA Confirmation: I have had the opportunity to read and understand the Health Insurance Portability and Accountability Act policies in use by Heart Clinic of Colorado.

Photograph: I hereby consent Heart Clinic of Colorado to photograph me (or my minor child) and relieve HCC of any responsibility for the use of my photograph for treatment, identification, and education purposes only.

Assignment & Release: I agree to assign directly to Heart Clinic of Colorado all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the attending medical providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

FINANCIAL AGREEMENT

I agree to pay HCC for all services provided to me by HCC and others for whom HCC collects bills at regular rates. This includes services, which, for any reason, are not paid by insurance, government programs or other third-party sources. I understand that any self-pay balance remaining unpaid after 30 days will incur a service charge of 1% per month on the principal unpaid balance. I further agree to pay reasonable attorney's fees and all costs of collection in the event my account is turned over to an attorney or collection agency.

I authorize payments to be made directly to HCC of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided to me. I understand professional (physician) services for radiology, laboratory, and pathology are charged separately from my clinic bill and that I am financially responsible to those physicians for any charges for their professional services of such physicians accept assignment of insurance benefits, I authorize insurance payments to be made directly to those physicians.

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In the event that I have been referred to Heart Clinic of Colorado for testing purposes only (i.e. echo, carotid, stress test, event monitor), with supervision and interpreting of this test the cardiologist has not performed a cardiology consult. He/she will not assist, or be responsible for my medical management unless cardiac consultation for diagnosis and/or management is formally requested by my doctor. The estimated fees for any testing are payable and collected on the date of service. The fee collected is for HCC only. Depending upon the type of test(s) you are having, you may receive additional billing through outside companies. Furthermore, your insurance company does not guarantee payment. Payment is based upon your participation agreement and the terms of the enrollee's benefits plan.

I understand that this consent form will valid and remain in effect as long as I (he/she) attend the clinic. This form has been fully explained to me and I understand its contents.

I HAVE BEEN GIVEN A COPY OF THE PATIENT AGREEMENT FORMS AND CONSENT TO ALL TERMS STATED IN THE DOCUMENTS. I KNOW THAT I CAN EITHER REQUEST A COPY OR FIND ONE ONLINE IF I WOULD LIKE ONE FOR MY OWN PERSONAL RECORDS.

By signing the document, you authorize us to send your medical information to your care providers and to leave information regarding your care/treatment on your home phone answering machine.

Patient Printed Name_____Date_____

Patient Signature_____

Office Employee Initials _____

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Patient Information and Authorization

In condition of the services and care to be furnished to me by Heart Clinic of Colorado:

CONSENT FOR GENERAL CARE

I present myself for health care services at HCC to be provided by authorized employees of the clinic and medical staff as may, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend patients are medical, nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne disease to include Hepatitis B Virus and Human Immunodeficiency Virus (AIDS).

AUTHORIZATION TO RELEASE INFORMATION

I authorize HCC to disclose information from my medical records (including transfer records) and/or my business office records to whom HCC believes is responsible for the payment of my bill or is involved in my care and treatment. Should any portion of my records contain information regarding drug or alcohol abuse, consent is given to release such information necessary to obtain payment of my bill from insurance companies or other funding sources. I may revoke this consent at any future date upon written notification in good faith from the date I sign this consent until the date I may choose to revoke it.

OCCUPATIONAL HEALTH SERVICES

I consent to a physical examination/evaluation or testing to be performed by the staff of HCC and any affiliated sites. I understand that I can expect an explanation of findings of the physical examination and any tests performed. No treatment is expected in connection with this exam/testing as it is for evaluation purposes only. I understand that my employer or insurer who is requesting this examination may be responsible for reimbursing HCC or affiliated sites per company policy. Access to information from this evaluation/testing shall follow applicable statutes and regulations.

MEDICARE/MEDICAID PATIENTS

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished my by HCC including physician services, and assign such benefits to HCC. I authorize HCC to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

X_____ _____

Signature of patient/Authorized Representative Date

_____**- I acknowledge being offered the Heart Clinic of Colorado Notice of Privacy**

Initial **Practices**

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FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing Heart Clinic of Colorado. Please review this Fee Agreement and Financial Policy, which describes charges not covered by insurance and additional fees. Please be sure you understand the policies regarding court advocacy and legal services, cancellations/missed appointments and non-sufficient funds. If you have any questions about anything, **please ask HCI staff prior to signing this Agreement and Policy**.

COURT ADVOCACY AND LEGAL SERVICES, THIS DOES NOT INCLUDE DIRECT PATIENT CARE, NOT COVERED BY INSURANCE CARRIERS

- Non-Patient Requested Medical Records $15.00 per request
- Indirect Services by a Licensed Provider (Medical or Behavioral Health)* $130.00 (pro-rated per 15 min.)
  ***Indirect services we provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.**
- Court Mandated Phone Consultations (11-60 min.) $130.00 (pro-rated per 15 min.)

ADDITIONAL FEES

- Late Cancellations/Missed Medical Appointment – notice fewer than 24 hrs. prior to appointment $25.00
- Late Cancellations/Missed Testing Appointment– notice fewer than 24 hrs. prior to appointment $50.00 and $150.00 for Nuclear Stress/ Lexiscan
- Non-sufficient funds (bounced) check $25.00

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *Heart Clinic of Colorado.*

I have read the Agreement and Policy above. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Healthy Connections, Inc. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by an authorized representative of Healthy Connections, Inc.

Patient name(printed)_____

Patient /Guardiansignature:_____

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RESTRICTIONS OF USE AND DISCLOSURE REQUEST FORM

Heart Clinic of Colorado recognizes an Individual's right to request that certain medical information (PHI) not be disclosed for purpose of payment, health care operations and certain notifications of disclosures. Heart Clinic of Colorado will consider all requests submitted but does not have to agree with such request. If Heart Clinic of Colorado does not agree with request, patient will be notified in writing within 60 days of request submission. If a request is granted, Heart Clinic of Colorado will comply with all requests unless request restriction is terminated, disclosure is deemed necessary for your care in an emergency situation or disclosure is legally permissible or required.

Patient's Name: _____ Date: _____

Specific information requesting to be restricted and reason(s)why: _____

_____

_____

If request is due to nondisclosure to health insurance how will patient pay for services: _____

_____

** All approved request terminations must be submitted in writing. Any new requests must be submitted on a separate form and will be reviewed for approval. Not all requests submitted will be approved. **

Patient's Signature:_____ Patient's Name: _____

For Office Use Only

Date of request submission: _____ Submission given to: _____

Reviewer: _____ Request: ☐ Approved ☐ Denied

Reason for denial (if applicable): _____

Date notification letter mailed to patient: _____

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HEART CLINIC OF COLORADO

Disclosure of Physician Ownership Notice to Patients

Please carefully review the information contained in this notice. This is furnished to all patients of Heart Clinic of Colorado. In the event you are scheduled for Diagnostic Sleep Services or evaluation at Mountain Sleep Diagnostics, Inc., or through Novasom, you need to know and acknowledge the following:

1. Our physician, Vito Calandro, M.D. FACC, is an owner of and has interest in Mountain Sleep Diagnostics, Inc. and Novasom;
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Mountain Sleep Diagnostics, Inc. or Novasom;
3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Mountain Sleep Diagnostics, Inc. or Novasom.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office ant Heart Clinic of Colorado or Mountain Sleep Diagnostics, Inc. or Novasom. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Mountain Sleep Lab and Novasom.

Signature of Patient

Signature of Parent or Guardian
(If applicable)

Type or Print Name of Patient

Type or Print Name of Parent or Guardian
(If applicable)

Date: _____