WELCOME TO CHANGE OF HEART CARDIOLOGY

Name_____Age_____ Date_____

Address_____ Birthdate_____

Who Referred you to our office?_____Occupation_____

Name/ Address of Nearest Relative_____ Their Phone_____

Date of last physical examination_____

Routine Check up – No symptoms _____

Please list all symptoms you had

1._____
2._____
3._____
4._____
5._____

Are you:
Single Married Divorced Widow(er)

	If Living Age	Health	If Deceased Age of Death	Cause
Father				
Mother				
Brother/Sister	1.			
	2.			
	3.			
	4.			
	5.			
Husband/Wife				
Son/Daughter	1.			
	2.			
	3.			
	4.			
	5.			

Has any blood relative ever had:	Please encircle:	
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Stroke	No	Yes
Epilepsy	No	Yes
Insanity	No	Yes
Suicide:	No	Yes

NOTE: This is a confidential record and will be kept in this office. Information will not be released to any person unless you have authorized us to do so.

PERSONAL HISTORY

ILLNESSES: Have you ever had

Childhood Diseases:	No	Yes	Cancer	No	Yes
Scarlet Fever or Scalatina	No	Yes	Elevated Cholesterol	No	Yes
Rheumatic Fever/Heart Disease	No	Yes	Elevated Triglyceride	No	Yes
Nephritis	No	Yes	Heart Attack	No	Yes
Gallbladder Disease	No	Yes	Angina	No	Yes
Anemia	No	Yes	High or low blood pressure	No	Yes
Jaundice	No	Yes	Colitis or bowel disease	No	Yes
Bladder disease	No	Yes	Hemorrhoids or any rectal disease	No	Yes

Epilepsy	No	Yes
Migraine Headaches	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes

Nervous Breakdown	No	Yes
Hay Fever or Asthma	No	Yes
Frequent infections or boils	No	Yes
AIDS	No	Yes

Any other disease: _____

ALLERGIES: Are you allergic to

Penicillin or Sulfa	No	Yes
Aspirin/Codeine/Morphine	No	Yes
Mycins/Other Antibiotics	No	Yes
Iodine	No	Yes
IVP Dye	No	Yes
Foods	No	Yes
Tetanus Antitoxin/Serums	No	Yes

Other Medications_____

TRANSFUSIONS: Have you had any

Blood/Plasma Transfusion	No	Yes
Most recent chest x-ray	No	Yes
DO YOU SMOKE?	No	Yes

Cigarettes_____
Cigars_____
Pipe_____
If Yes
How many Packs/Day?_____
For how many years?_____
Do you Drink Alcohol?_____oz/day_____
Do you drink coffee?_____cups/day_____
Do you get regular exercise? No Yes
If Yes, what type?_____
_____

INJURIES: Have you had any

Broken Bones	No	Yes
Sprains	No	Yes
Concussion/Head Injury	No	Yes

WEIGHT: Now_____
1 Year ago_____
Maximum_____
When_____

CARDIAC TESTING: have you ever had

EKG Electrocardiogram	No	Yes
Echocardiogram	No	Yes
24 HR Holter Moniter	No	Yes
Stress Test (Exercise Test)		
Regular	No	Yes
Nuclear	No	Yes
Cardiac Catherization	No	Yes
Angioplasty	No	Yes
Coronary Artery Bypass	No	Yes

(Number of Vessels) _____
Other Cardiac Procedures or Surgery List With dates:
_____
_____

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent/Severe headaches	No	Yes
Fainting Spells	No	Yes
Dizziness on change of position	No	Yes
Unconscious spells	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes
Spots before eyes	No	Yes
Infected eyes	No	Yes
Pain behind eyes	No	Yes
Any change of vision	No	Yes
Do you wear glasses	No	Yes
Earaches	No	Yes
Ringing in ears	No	Yes
Decrease in hearing	No	Yes
Recurrent nose bleeds	No	Yes
Recurrent head colds/Sinus	No	Yes
Hay fever	No	Yes
Strange persistent odors	No	Yes
Strange taste/ loss in taste	No	Yes
Persistent hoarseness	No	Yes
Difficulty swallowing	No	Yes
Enlarged glands	No	Yes
Recurrent sore throats	No	Yes
Recurrent sores in mouth	No	Yes
Sore/Bleeding gums on brushing	No	Yes
Chest Pain	No	Yes

Wake up night short of breath	No	Yes

How many bed pillows do you use?_____

Shortness of breath:		
Walking several blocks	No	Yes
One flight of stairs	No	Yes
On laying down	No	Yes
Purple lips or fingers	No	Yes
Palpitations/fluttering of heart	No	Yes
High Blood Pressure	No	Yes
Swelling of hands/feet/ankles	No	Yes

At what time of day _____

Leg cramps on walking or at night	No	Yes
Enlarged veins in legs	No	Yes
Recurrent stomach pain	No	Yes
Belching or heartburn	No	Yes

Relieved by food or medication_____
Appetite – Good _____Fair____Poor_____

Nausea or vomiting	No	Yes
Vomited blood	No	Yes
Avoid some foods	No	Yes

What kinds_____

Avoid spices	No	Yes
Abdominal cramping	No	Yes
Color of bowel movement	No	Yes
Any blood in bowel movement	No	Yes
Rectal pain w bowel movement	No	Yes

Angina Pectoris	No	Yes	Pain in urinating	No	Yes
Coughed up blood	No	Yes	Difficulty in starting urination	No	Yes
Pain in arm(s)	No	Yes	Do you get up at night to urinate	No	Yes
Night sweats	No	Yes	How many times_____		
Chronic/frequent cough	No	Yes	Do you urinate more or less than before?_____		
Discharge from penis	No	Yes	Growth in neck or throat	No	Yes
Recurrent back pains	No	Yes	Hot flashes	No	Yes
Backaches	No	Yes	Tiredness w/o apparent reason	No	Yes
Joint aches	No	Yes	Brittleness of nails	No	Yes
Swelling of any joints	No	Yes	Dryness of skin	No	Yes
Tingling/weakness in hands/feet	No	Yes	Easy bruising	No	Yes
Muscle spasms	No	Yes	Inability to stand heat	No	Yes
Loss in sensation hands/feet	No	Yes	Inability to stand cold	No	Yes
Trembling of any extremity	No	Yes	Any skin rash	No	Yes

SURGERY: List

Type_____Year_____
Type_____Year_____
Type_____Year_____

HOSPITALIZATIONS: List

Why_____Year_____
Why_____Year_____
Why_____Year_____

_____

List all current medications and Dosage (Including eye drops, and Inhalers taken on an "As Needed Basis")

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Change of Heart Cardiology and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the office with any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance carrier received the claim. I am responsible for the entire bill or balance of the bill as determined by Change of Heart Cardiology and/or my health care insurer if the submitted claims or part of them are denied for payments. I understand that by signing this form that I agree that if my account is referred to an outside agency or attorney for collections, I will be responsible for an additional Collection Fee of fifty dollars ($50.00) or 25% of the balance owed, whichever amount is greater.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Change of Heart Cardiology for all covered medical services and supplies provided to me during all courses of treatment and care provided by Change of Heart Cardiology and/or its affiliate entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Change of Heart Cardiology, and will constitute a continuing authorization, maintained on file with the Change of Heart Cardiology, which will authorize and allow for direct payment to Change of Heart Cardiology or all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by Change of Heart Cardiology.

Authorization to Release Information

I authorize the release of any medical or any other information to my insurance carrier (s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Change of Heart Cardiology. A copy of this authorization will be sent to my insurance carrier (s), or other medical entity, if requested. The original authorization will be kept on file by Change of Heart Cardiology.

_____ _____

Patient (Printed Name) **Date**

_____ _____

Social Security Number **Date of Birth**

_____

Patient Signature

Notice of Privacy Practices: Change of Heart Cardiology, LLC

As required by the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YO CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective Date: April 14, 2003 Updated February 18, 2009

Understanding Your Health Record / Information

Each time you visit out office, or another physician or health care provider contacts us concerning your medical needs or history a record is made by our office. This record contains medical information generated during your visits to our office, received by our office from other health care providers, or provided by you. In this "Notice of Health Information Practices", we shall refer to the information contained in your record as your "health Information". This term shall have the same meaning as "Protected Health Information (PHI)" defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

Your Health Information Rights

Within the limits provided by federal and state law, you have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Receive confidential communications of your health information. You may request that we communicate with you about your health information by alternative means or an alternative location;
- Inspect and obtain a copy of your health information, except with regard to psychotherapy notes or information compiled in reasonable anticipation of certain civil, criminal or administrative proceedings;
- Request an amendment of your health information that we have created, except with regard to those portions of your health information that you are precluded from inspecting and copying as set forth above;
- Obtain an accounting of certain disclosures of your health information; and
- Receive a paper copy of this Notice in addition to any electronic copy you may receive.

You may exercise any of the above rights by submitting a signed letter detailing your request and mailing or delivering the letter to a Physician or the Privacy Contact in our office. However, we encourage you to call first so that we can help you be as specific as possible with your request. We will promptly provide you with any forms needed to process your request.

Our Responsibilities

This office is required by law to:

- Maintain the privacy of your health information;
- Provide you with this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you;
- Abide by the terms of this Notice, currently in effect, and as amended from time to time;
- Notify you if we are unable to honor your request to restrict a use or disclosure of, or to amend, your health information, and
- Accommodate reasonable requests you may have to communicate your health information by alternative means or at alternative locations.

We reserve the right to change our privacy practices and to make the new provisions effective for all of your health information we already have, as well as any health information we receive or create in the future. Should our privacy practices change, we will post a copy of the revised Notice in our waiting area, which indicates the effective date of the amended Notice. You may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

If a use or disclosure of your health information is not permitted under law without a written authorization, we will comply with this restriction, except to the extent that we have already taken action in reliance of your authorization.

For more Information or to Report a Problem

If you have questions and would like additional information concerning this Notice, please call our HIPAA Compliance Officer, Dr. Scott Eisenberg at (732) 974-6700. If you believe that we have violated any of your privacy rights, you may file a written complaint with our HIPAA Compliance Officer, Dr. Scott Eisenberg, c/o Change of Heart Cardiology, 1944 Corlies Avenue, Neptune, New Jersey, 07753. You may also file your complaint with the Secretary of Health and Human Services. To file a complaint with the Government you may contact the Secretary of the Department of Health and Human Services (DHHS), 200 Independence Avenue, SW, Washington, DC 20201; telephone 1-877-696-6775. We promise not to retaliate against you for any complaint you make to the government about our privacy practices. There will be no penalty or retaliation for filing a complaint.

Examples of Uses and Disclosures for Treatment, Payment and Health Operations The following are examples of uses and disclosures of your health information, which are permitted by law.

We will use your health information for treatment: We will use your health information to provide medical services to you. Any of our staff involved in your care will have access to your health information. We may also provide your health information to other health care providers involved in your care to assist them in providing services to you. **However, we will not disclose psychotherapy notes to health care providers who are not originators of those notes unless we have your written authorization to do so.**

We will use your health information for payment. Your health plan or insurer will require certain information about your condition and the services you receive from us, before payment will be made, or for pre-authorization purposes. Accordingly, for billing purposes, we may disclose your health information to your health plan or health insurer when they require pre-authorization of a recommended procedure.

We will use your health information for regular health care operations. Members of our staff may review and use health information from your record to assess the care and outcomes in your case and others like it. We will then use this information in an effort to continually improve the quality and effectiveness of our services.

Additional Uses and Disclosures

Business Associates: Certain of our business operations may be performed by other businesses. We refer to these companies as "Business Associates." In order for these business associates to perform the required service (billing, practice management company, accounting services, etc.), we may need to disclose your health information to them so that they can perform the job we have asked them to do. To protect you, we require our business associates to appropriately safeguard your health information.

Communication with Persons Involved in Your Care: We may disclose your health information that is directly relevant to your care to individuals you wish to receive such information, including family members, relatives, close friends, or other persons you identify. Before we do so, we will ask you, and follow your instructions, as to whether or not to make such disclosures. If you are incapacitated, or involved in an emergency, we may use or make disclosures of your health information that we believe in our professional judgment are in your best interests, but only to the extent, that such health information is directly relevant to the recipients' involvement in your care.

Required by law: We may use or disclose your health information upon request to the extent such use or disclosure is required by law and is limited to the relevant requirements of such law.

Public Health, Health Oversight and the Food and Drug Administration (FDA): As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also be required by law to disclose your health information to health oversight agencies responsible for regulation the health care system, government benefit programs, and civil rights laws, so that they may conduct, among other things, audits, investigations and inspections. For the purpose of activities relating to the quality, safety or effectiveness of a FDA-regulated product or activity, we may disclose to the FDA your health information relating to adverse events with drugs, supplements, and other products, as well as information needed to enable product recalls, repairs or replacements.

Victims of Abuse, Neglect or Domestic Violence: If we reasonably believe that you are the victim of abuse, neglect or domestic violence, we may disclose your health information to a governmental authority responsible for receiving these types of reports, to the extent the disclosure is required by law, or you agree to the disclosure. If the disclosure is authorized by law, but not required, we may disclose your information if we determine that disclosure is necessary to prevent serious harm to you or others.

Judicial and Administrative Proceedings: If you are involved in a judicial or administrative proceeding, we may, in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process, disclose the specific portions of your health information that are requested. If the subpoena, discovery request, or other lawful process is not accompanied by a court or administrative tribunal order, we may disclose your health information only after we are assured that reasonable efforts have been made to notify you of the request and the time for you to raise objections to the request has expired, or reasonable efforts have been made by the requestor to seek a protective order concerning the requested health information.

Law Enforcement: We may disclose your health information to a law enforcement official for law enforcement purposes as required by law, upon presentation of a court ordered subpoena or summons, a grand jury subpoena or summons, or an administrative subpoena or summons, under certain circumstances. In specific situations, the law also permits us to disclose limited pieces of your health information, when the information is needed by law enforcement officials to: 1) Identify a suspect, fugitive, material witness, or missing person, 2) Identify a victim of a crime, 3) Alert law enforcement officials of your death, 4) Notify law enforcement officials when a crime has been committed on our premises, or, 5) In an emergency, when necessary to alert law enforcement officials about a crime, its location, or the identity of a perpetrator.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner or medical examiner for the purposes of identifying you upon your passing, or to determine a cause of death. We may also disclose your health information to your funeral director if needed to complete his or her authorized duties.

Organ, Eye or Tissue Donation: If you are an organ, eye or tissue donor, we may release your health information to organizations that procure, bank, or transplant organs for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information, thereby meeting the requirements under HIPAA. We may also disclose your health information for the purposes of research, public health or health care operations pursuant to a Data Use Agreement protecting that information as specified by HIPAA.

Avert a Serious Threat to Health or Safety; Consistent with applicable law and standards of ethical conduct, we may, in limited circumstances, use or disclose your health information if we, in good faith, believe such use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public.

Military Personnel; If you are a member of the United States Armed Services, we may disclose your health information to the appropriate military command authority when such information is deemed necessary to assure the proper execution of the military mission. **(Note: Additional disclosures are required if you are a part of the Department of Defense, Transportation, State or Veterans Affairs.)**

National Security and Presidential Protective Services: We may disclose your health information to authorized federal officials for the conduct of lawful intelligence and national security activities as well as the provision of protective services to the President and other protected individuals.

Inmates and Individuals in Custody: If you are an inmate or otherwise in custody, we may disclose your health information to the correctional facility or law enforcement official having lawful custody of you.

Workers' Compensation: We may disclose your health information to the extent authorized and necessary to comply with laws relating to Workers' Compensation or other similar programs established by law.

Appointment Reminders and Information on Treatment Alternatives: We may contact you to provide you with appointment reminders, information concerning treatment alternatives or other health related benefits, and/or other alternatives and services that may be of interest to you.

Communication Barriers: We may use and disclose your health information if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Change of Ownership: Our Practice may use and disclose your PHI (Protected Health Information) in the event that our Practice is sold or merged with another organization and your PHI/Health Records may then become the property of the New Owner.

FOR ALL OTHER CIRCUMSTANCES, WE MAY ONLY USE OR DISCLOSE YOUR HEALTH INFORMATION AFTER YOU HAVE SIGNED AN AUTHORIZATION PERMITTING SUCH USE AND/OR DISCLOSURE(S). If you authorize us to use or disclose your Health Information for another Purpose, you may revoke your authorization in writing at any time.

Your rights regarding your PHI: You have the following rights regarding the PHI that we maintain about you:

Confidential Communications: You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather that at work or at an alternate address. Our Practice will accommodate reasonable requests. We may also condition this request by asking you how payment will be handled. You do not need to give a reason for your request. **Please make this request in writing to our Privacy Contact.**

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request:** however, if we do agree, we are bound by our agreement except; when otherwise required by law, in an emergency, or, when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, **you must make your request in writing to our Privacy Contact.** Your request must describe in a clear and concise fashion:

- The information you wish to restrict,
- Whether you are requesting to limit our Practice's use, disclosure, or both,
- To whom you want the limit(s) to apply.

Inspection and Copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You **must submit your request in writing to our privacy Contact** in order to inspect and/or obtain a copy of your PHI. Our Practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our Practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, **your request must be made in writing and submitted to our Privacy Contact and you must complete paperwork available at the Practice.** You must provide us with a reason that supports your request for an amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing on a form that we will provide. Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete; (b) not part of the PHI kept by or for the Practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures: All our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our Practice has made of your PHI for purposes not related to treatment, payment or operations use of your PHI as part of the routine patient care in our Practice is not required to be documented. We do not have to account for our disclosures:

- Authorized by patients
- Made for treatment, payment, or health care operations
- Information provided to patients
- Notification and communication with family
- Certain government functions
- Appointment reminders

In order to obtain an accounting of disclosures, you must submit your request in writing to our Privacy Contact. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our Practice may charge you for additional requests, and you may withdraw your request before you incur any costs.

OUR PLEDGE

We will endeavor to protect the privacy of your health Information. If you have any questions, comments or concerns regarding the policies set forth above, please do not hesitate to discuss such matters with Our Privacy Contact or your Physician. End of Document.

Change of Heart Cardiology LLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices

Name of Patient: _____Date of Birth:_____

Signature of Patient: _____ Date:_____

Please list anyone that you give your permission to have your personal health information:

_____

_____

_____

I also authorize the release of appointment information, "my results", such as laboratory, diagnostic, x-ray, clinical findings, and consultations by phone to the following number:

_____

This information may be left on the answering machine at the same number: **Yes** **No**

In the event the patient is unable to sign:

Signature of Representative: _____ Relationship:_____

Date:_____

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

_____ Refused to sign _____Physically Unable to Sign

(Other)

_____

Employee Signature and Date: _____