**PONDEROSA HEART**

2162 E. WILLIAMS FIELD
GILBERT, ARIZONA 85295
P: 480.795.1515 • F: 480.597.1723
E-Mail: info@myheartmyhome.org

DATE:_____

## PATIENT DEMOGRAPHICS

NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____-_____-_____ ☐ MALE ☐ FEMALE

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PRIMARY PHONE:_____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

APPOINTMENT PHONE:_____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

E-MAIL ADDRESS:_____

PRIMARY INSURANCE CARRIER:

_____

SUBSCRIBER ID:_____

GROUP ID: _____

SECONDARY INSURANCE CARRIER (IF APPLICABLE):

_____

SUBSCRIBER ID:_____

GROUP ID: _____

EMERGENCY CONTACT:_____ RELATION:_____

PHONE:_____ E-MAIL:_____

## PREFERRED PHARMACY

PHARMACY NAME:_____ PHONE:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

## LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1._____ 2._____

3._____ 4._____

5._____ 6._____

## LIST ANY PHYSICIANS AND/OR PRACTITIONERS YOU CURRENTLY SEE

NAME:_____ SPECIALTY:_____

NAME:_____ SPECIALTY:_____

NAME:_____ SPECIALTY:_____

NAME:_____ SPECIALTY:_____

## LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

| NAME | STRENGTH | DIRECTION | PRESCRIBED BY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## LIST ANY ALLERGIES TO MEDICATION. X-RAY DYES OR FOOD

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

## LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. _____ YEAR: _____ 2. _____ YEAR: _____

3. _____ YEAR: _____ 4. _____ YEAR: _____

5. _____ YEAR: _____ 6. _____ YEAR: _____

## PATIENT HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| ANEMIA | | | JAW PAIN | | |
| ARTHRITIS, RHEUMATISM | | | KIDNEY DISEASE | | |
| ASTHMA | | | LIVER DISEASE | | |
| BACK PROBLEMS | | | LOW BLOOD PRESSURE | | |
| CANCER | | | LUNG DISEASE | | |
| CAROTID ARTERY DISEASE | | | MIGRAINES | | |
| CHEMICAL DEPENDENCY | | | NEUROLOGICAL DISEASE | | |
| CHEMOTHERAPY | | | PROSTATE DISORDER | | |
| CIRCULATORY PROBLEMS | | | RESPIRATORY DISEASE | | |
| COUGH | | | SHORTNESS OF BREATH | | |
| DIABETES | | | SINUS TROUBLE | | |
| EMPHYSEMA | | | SPINAL INJURY | | |
| EPILEPSY | | | STROKE | | |
| FAINTING OR DIZZINESS | | | SWOLLEN FEET OR ANKLES | | |
| GASTROINTESTINAL DISEASE | | | SWOLLEN NECK GLANDS | | |
| GLAUCOMA | | | THYROID PROBLEMS | | |
| HEPATITIS – TYPE: | | | TUBERCULOSIS | | |
| HIGH BLOOD PRESSURE | | | ULCERS | | |
| JAUNDICE | | | OTHER: | | |

## RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

| | |
|---|---|
| COVID19 VACCINE YEAR: | BONE DENSITY SCAN YEAR: |
| COVID19 BOOSTER (1) YEAR: | MAMMOGRAM YEAR: |
| COVID19 BOOSTER (2) YEAR: | ECHOCARDIOGRAM YEAR: |
| PNEUMONIA VACCINE YEAR: | PAP SMEAR YEAR: |
| SHINGLES VACCINE YEAR: | GLUCOSE READING YEAR: |
| HEPATITIS B SHOT YEAR: | HEMOCCULT TEST YEAR: |
| FLU VACCINE YEAR: | PSA TEST YEAR: |
| TETANUS DIPHTHERIA YEAR: | LIPID PANEL YEAR: |
| COLONOSCOPY YEAR: | HEARING EXAM YEAR: |
| PROSTATE EXAM YEAR: | GLAUCOMA/EYE EXAM YEAR: |
| RECTAL EXAM YEAR: | NUTRITIONAL THERAPY YEAR: |
| PELVIC EXAM YEAR: | SMOKING CESSATION YEAR: |
| ABDOMINAL AORTIC ANEURYSM SCREENING YEAR: | |
| DIABETES SELF-MANAGEMENT TRAINING YEAR: | |

## HEALTH CARE CONSENT FOR TREATMENT

**REVIEW.** In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign at the bottom only after careful review and consideration.

**CONFIDENTIALITY.** I understand that no information regarding services performed shall be released without my express consent except as follows: I authorize those copies of my records may be sent to another location if I seek additional treatment at that location. I understand that, in addition to authorized Advanced Practitioner herein stated to be either a Physician Assistant (PA) or Nurse Practitioner (NP), the supervising/collaborating physician(s) shall have full access to my treatment records. I understand that an appropriate medical review may be conducted to further the safety and efficacy of my Advanced Practitioner's services. I understand my Advanced Practitioner may also provide limited patient information to various third-party vendors to provide database development and maintenance services, referral services, or marketing research services. I understand that photographs may be taken to document treatment results, but they will not be released or used otherwise without my specific written consent. My Advanced Practitioner will maintain file
copies of all records for a minimum of seven years.

**SERVICES.** Collectively the Cardiac Services offered in the home and the Cardiac Services and procedures not offered in the home are referred to herein as the "Cardiac Services." Ponderosa Heart House Call ("PHHC") provides the following cardiac care services: Cardiac consultations (in-person and/or via telehealth), cardiac disease and medication management, Diagnostic testing - ECG, Holter/event monitoring/cardiac outpatient telemetry monitoring, ABI, transthoracic echocardiography, upper/lower extremity arterial and lower
extremity venous imaging, pacemaker/defibrillator management and remote monitoring, abdominal aortic duplex scan, and anticoagulation management. Cardiac services not offered in the home are cardiac related surgical or interventional procedures (not limited to): cardiac catheterizations, balloon angioplasty, coronary artery /carotid artery/ peripheral vascular angiography/ angioplasty or stenting,
ASD/PFO closures, valvuloplasty, transcatheter aortic valve replacement (TAVR), pacemaker/defibrillator implantation, loop recorder implantation, electrical cardioversion, cardiac electrophysiology ablation, sclerotherapy, endovascular radiofrequency venous ablations, endovenous laser treatment (ELVT), or Enhanced External Counter-Pulsation (EECP), cardiac stress testing, or transesophageal echocardiography.

**ROUTINE PROCEDURES**. I acknowledge and understand that during the course of PHHC providing PCP and/or Cardiac Services to me various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered ordinary and necessary techniques for the services provided.

**DISCLOSURE OF MEDICAL HISTORY.** I agree that I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

**MATERIAL RISK OF TREATMENT PROCEDURES**. I understand that the medical provider, medical personnel and other assistants participating in the patient's care will rely upon my documented medical history (or if I am the patient representative, medical power of attorney or guardian) as well

as other information obtained from me, the patient, the family or others having knowledge regarding the patient, in determining the course of treatment for my/the patient's condition. All medical treatment involves risks. Risks associated with your PCP and/or Cardiac(s) include but are not limited to bruising, bleeding, heart attack, stroke, irregular heart rhythm's (arrhythmias), allergic reactions to
medications, kidney damage, infection, blood clots. Following or as part of your consultation please ask your Advanced Practitioner and/or attending medical provider if you would like additional information regarding the nature or consequences of these risks, and their likelihood of occurrence.

INFORMATION AND RISK. While the Cardiac Services are routinely performed in clinicians' offices, or in the home as described above, without incident, there are certain risks associated with providing Cardiac Services in the home. I understand that, while the Advanced Practitioner are responsible for providing me with information about the Cardiac Services and for answering my questions about them, it is not possible to enumerate each and every risk for every service or procedure utilized in modern health care. If I have further questions or concerns regarding Cardiac Services, I agree to ask the Ponderosa Heart House Call for more information.

PRINCIPLE CARE MANAGEMENT (PCM). Your health is very important to Ponderosa Heart. In alignment with our dedication to keep you as healthy as possible with a focus to keep you out of the hospital and minimize the costs and inconvenience of unnecessary visits to doctors, labs, or urgent care facilities -- You are eligible for a Principal Care Management. PCM involves managing chronic conditions
effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. This includes a non-face-to-face component of care that involves the creation of a patient-centered plan of care, medication monitoring, management of care transitions, electronic care coordination and exchange of health information with other health care providers as necessary, while providing you (and/or your caregiver) 24/7 access to your care team that is familiar with your conditions with 24/7 access (by you or your caregiver) to around-the-clock services, actively help you manage all your medications, coordinate visits with your providers, facilities, labs, radiology, and/or other medical services, provide a personalized and comprehensive care plan management, and assist with scheduling preventive care services, many of which are covered by insurance Only one provider can bill for this service for you. Please let us know if you have entered into a similar agreement with another provider or practice. You may discontinue this service at any time and for any reason. Your signature is required to end PCM services, so please notify us if you choose to discontinue the service, we will provide it only through the last day of the calendar month of your decision and provide you with a PCM revocation form. I consent to allow my advanced practitioner and their designees to perform PCM on my behalf. I understand that Ponderosa Heart House Call will bill my insurance for this service, and that I am responsible for any copayment or deductible. I understand that I can revoke this permission at any time by notifying Ponderosa Heart House Call in writing.

☐ Check here only if you DO NOT want PCM service.

SCOPE OF SERVICES AND SUPERVISION. I understand that, as required by law, the Advanced Practitioner which provide the PCP and/or Cardiac Services are subject to the supervision of a licensed physician who may observe and supervise the care of the Advanced Practitioner as required by law but is not required to participate in face-to-face patient care.

PAYMENT RESPONSIBILITY. The undersigned acknowledges responsibility to pay for all care that I receive in accordance with regular rates and terms of Ponderosa Heart House Call LLC. I allow Ponderosa Heart House Call LLC to bill my insurance for the services rendered. If my insurance provider or health benefit plan does not cover the full cost of such care, then I must pay the remaining balance. If payment obligations can't be met, then a payment arrangement must be made with Ponderosa Heart House Call LLC for payment to be paid in full within 60 days from the date of service. The undersigned certifies and authorizes to release information and payment request that the information given by me in applying for payment if under Medicare, Medicaid, or any other insurance carrier is correct. I authorize the release of all records required to act on this request.

RELEASE AGREEMENT. The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Ponderosa Heart House Call LLC may disclose portions of the undersigned records, including any medical records to any person, corporation, or other entity liable for all, or any portion of the facility charges. This includes, but not limited to insurance companies, health care service plans, and workers compensation carriers.

□ TEXT MESSAGEING. The By checking this box, you agree that PHHC may send you information in two way messages regarding your appointments, care, exc. Messaging and Data rates may apply. For more information contact PHHC.

ASSIGNMENT OF BENEFITS. The undesigned, in consideration of the services provided to the patient by PHHC I hereby assign and transfer to PHHC and other appropriate health care providers all health care benefits payable and related rights, including my rights to appeal any denial of benefits or limitation of coverage existing under the insurance policies or benefit plans that I have identified
or will identify in connection with the patient's medical care. I authorize and direct the insurance company or benefit plan to pay all such benefits to Ponderosa Heart House Call LLC, and I appoint Ponderosa Heart House Call LLC to act as my authorized representative in requesting an appeal from my insurance company or benefit plan regarding any denial of payment. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by my insurance company or benefit plan, unless otherwise provided in the terms of an agreement between Ponderosa Heart House Call LLC and the insurance company or benefit plan.

CERTIFICATION. The certifies that undersigned has received and read the above information by the patient, patient's legal representative or their duly authorized to be the patient's general agent to execute this agreement and consent and accept its terms.

DIGITAL IMAGES. I understand that digital and other images may be recorded to document the patient's care and I consent to such

rights to these digital and other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner in PHHC electronic health record and kept for the time period required by law and/or outlined in PHHC policy.

NO GUARANTEE OF TEST RESULTS TO TREATMENT OUTCOMES. I understand that the practice of medicine is not an exact science and that no guarantees or assurances are made to me concerning the outcome and/or result of any Cardiac Services.

WARRANTIES AND DISCLAIMERS. PHHC shall provide Cardiac Services as described to the patient in consultation. While PHHC has the discretion to perform or provide additional medical services as it deems necessary it has no duty to so. PHHC disclaims and shall have no duty to provide any other service or benefit not described to the patient and approved by PHHC.

LIMITATION OF LIABILITY. PHHC shall not be responsible for, and shall not pay, any amount of incidental, consequential or other direct or indirect damages, whether based on lost revenue, lost profits, loss of goodwill or otherwise, regardless of whether I was advised of the possibility of such losses in advance, or for any compensation, exemplary, punitive or damages except as set forth herein. In no event shall the liability of PHHC or its principals and agents hereunder exceed the amount paid by you, the undersigned, for our PCP and/or Cardiac Services regardless of whether your claim is based on contract, tort, strict liability, product liability or otherwise. In any case, your sole remedy shall be a refund of our service fees or as explicitly described in any written warranty we may provide to you.

HIPAA NOTICE OF PRIVACY PRACTICE. The following in a summary of the Ponderosa Heart House Call HIPPA Privacy Practices. A complete copy of Ponderosa Heart House Call HIPAA Notice of Privacy Practices can be obtained by requesting in writing. Our Obligations: We are required by law to: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice that is currently in effect: for treatment, payment, healthcare operations, appointment reminders, treatment alternatives, and health related benefits and services, individuals involved in your care or payment for your care, research, as required by law to avert a serious threat to health or safety, business associates, organ and tissue donation, military and veterans, workers compensation, public health risks, health oversight activities, data breach notification purposes, laws and disputes, law enforcement, coroners, medical examiners, and funeral directors, national security and intelligence activities, protective services for the President and others, inmates or individuals in custody. Your Rights include: Right to inspect and copy, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, out-of-pocket payments, right to request confidential communications. If you believe your privacy rights have been violated, you may file a complaint with our office or with the secretary of the department of health and human services. To file a complaint with our office, contact Ponderosa Heart House Call at (480) 795-1515. All complaints must be made in writing. You will not be penalized for filing a complaint. The undersigned patient or legally authorized representative ("Patient Representative") of the patient acknowledges that he or she has reviewed Ponderosa Heart House Call notice of HIPAA privacy practices on a date indicated below.

CONSENT. I hereby authorize and give voluntary consent to PHHC and its healthcare professionals to provide me (or if I am the patient representative, medical power of attorney or guardian) with one or more of the above Cardiac Services, which may require a continuing course of Cardiac Services or related medical action. I consent to and authorize the persons participating in and responsible care to utilize Cardiac Services that they deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this Consent is obtained. This Consent shall also extend to the treatment of all conditions which may arise during the course of such Cardiac Services and Procedures, including those conditions which may be unknown or unforeseen at the time this Consent is obtained.

☐ Patient /patient representative acknowledges that they have received a written copy of and understand the contents therein of their patient rights in accordance with *Patient Rights* R9-10-1008

PRINTED NAME – Patient/Patient Representative

X

SIGNATURE – Patient/Patient Representative

DATE

## ADVANCE DIRECTIVES

I understand that the *Federal Patient Self-Determination Act of 1990* requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have reviewed and understood my "Patient Advance Directive Statement" as described below and I have been given written information concerning Advance Directives and my rights and responsibilities. I understand the Practice will honor all my Advanced Directives. I understand that if I want more information or would like to create my own Advance Directive, I can do so either online at: https://azhdr.org by calling *602-368- 6371*, or via email at *support@azhdr.org*.

☐ I would like more information regarding Advance Directives and will use the above references to begin the process.

☐ I would like to execute one or more Advance Directives but will begin the process with another resource.

☐ I have a living will: ☐No ☐Yes If Yes, copy obtained: ☐No ☐Yes

If No, describe the patient's wishes: _____

_____

☐ I have a health care power of attorney:

If Yes: Name: _____

Phone: _____ E-mail: _____

☐ I have an Advance Directive: ☐No ☐Yes If Yes, copy obtained: ☐No ☐Yes

If No, describe the patient's wishes: _____

_____

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

_____

PRINTED NAME – Patient/Patient Representative

X _____ _____

SIGNATURE – Patient/Patient Representative DATE

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# MEDICAL RECORDS RELEASE AUTHORIZATION

## PATIENT INFORMATION

Patient's Full Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

E-Mail Address: _____

## AUTHORIZATION RECIPIENT INFORMATION

**IF RELEASING TO AN INDIVIDUAL**

Full Name: _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

**IF RELEASING TO A HEALTHCARE PROVIDER**

Office Name: _____

Provider Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

**IF RELEASING TO A COMPANY/BUSINESS (E.G. LEGAL OFFICE)**

Company Name: _____

Authorized Representative: _____

Company Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

## INFORMATION TO BE RELEASED

☐ Complete Medical Records

☐ Specific Date Range From: _____ To: _____

☐ Specific Information (describe): _____

_____

## PURPOSE OF RELEASE

☐ Transfer to New Healthcare Provider

☐ Legal Proceedings

☐ Caregiver/Family Member

☐ Other: _____

Patient Signature: _____ Date: _____

## PATIENT RIGHTS

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Sexual abuse;
    g. Sexual assault;
    h. Except as allowed in R9-10-1012(B), restraint or seclusion;
    i. Retaliation for submitting a complaint to the Department or another entity; or
    j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
    a. Except in an emergency, either consents to or refuses treatment;
    b. May refuse or withdraw consent for treatment before treatment is initiated;
    c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
    d. Is informed of the following:
        i. The outpatient treatment center's policy on health care directives, and
        ii. The patient complaint process;
    e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
    f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical record, or
        ii. Financial records.

A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patients rights.

☐ Patient /patient representative acknowledges that they have received a written copy of and understand the contents therein of their patient rights in accordance with *Patient Rights* R9-10-1008

PRINTED NAME – Patient/Patient Representative

X

SIGNATURE – Patient/Patient Representative

DATE