New Patient Packet

William Newton CARDIOLOGY

Date: _____

Dear _____,

You are scheduled for an appointment with Dr. Ryan Beard on _____.
appointment date

Location: Physician Pavilion
1230 E Sixth Ave, Suite 2C
Winfield Kansas 67156

Phone number: 620-222-6264 Fax: 620-800-1011

Appointment Notes:

+ Please complete the enclosed forms and bring them with you to your appointment.

+ Please bring your insurance card(s) AND photo ID to your appointment.
  - If you are a member of any insurance plan that requires a written referral and you do not obtain authorization from your primary care physician prior to your visit, you will be responsible for all charges at this appointment.

  - If you are a member of a managed health plan such as Coventry HMO/POS, AETNA, CIGNA, Tricare or UHC Compass, you will need to obtain written referral from your primary care physician. You may verify in advance that your referring physician's office is taking care of any necessary referrals. If you have any questions, please contact our office for assistance

  - If you are a self-pay, you will need to pay $50 at your visit. The remainder will be billed to you.

+ Bring all medications you are currently taking, in the bottles. If you are unable to bring the bottles, a medication list will suffice.

+ It is very important that we have your past pertinent medical records. Please verify that these records are being mailed or faxed to our office from your referring physician's office prior to your appointment. This allows our physician to review your records prior to your appointment.

+ If you have an ADVANCE DIRECTIVE/DNR/MEDICAL POWER OF ATTORNEY, please bring a copy with you.

PLEASE ARRIVE 15 MINUTES EARLY FOR YOUR APPOINTMENT

Demographic Info

William Newton CARDIOLOGY

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP:_____

Primary Phone Number: _____

Mobile Phone: _____ Work Phone: _____

Email Address: _____

Preferred contact method: ☐ Email ☐ Phone ☐ Postal

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Marital Status: ☐ Married ☐ Single ☐ Divorce ☐ Widowed ☐ Separated

Occupation: _____

Race/Ethnic Group: ☐ American Indian/Alaskan ☐ Asian/Pacific Islander
☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Other

Preferred Language: _____

Primary Insurance: _____

_____

Secondary Insurance: _____

_____

Pharmacy Name and Address: _____

Primary Care Physician: _____

Have you been seen by a cardiologist in the last five years? ☐ Yes ☐ No

If yes, please provide physician's name: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of information required for claim(s) to my insurance company(s). I also authorize those payments be made directly to William Newton Cardiology.

Signature _____ Date: _____

Guardian, if minor _____ Date: _____

Medical History

William Newton CARDIOLOGY

Medical History: *check all that apply*

☐ High blood pressure ☐ Heart Attack ☐ Stroke ☐ High Cholesterol
☐ Dizziness ☐ Coronary Artery Disease ☐ Chest Pain ☐ Palpitations
☐ Diabetes ☐ Irregular heartbeat ☐ Leg pain ☐ DVT
☐ Peripheral Vascular Disease ☐ Swelling in legs or feet ☐ Pulmonary embolism or clots

Any other medical history not listed above: _____

Allergies/Intolerance Food or Medications: _____

Current Medication List:_____

_____

Surgical History: _____

_____

Recent Hospital Stays: _____

_____

Family History: *check all that apply*

Family Member	Living?	Age	Heart Attack	High Blood Pressure	Diabetes	Stroke	Cancer	Congestive Heart Failure
Father								
Mother								
Sibling								
Sibling								

Social/Cultural History:

Smoker: ☐ Yes ☐ No ☐ Former

If yes, what type/how long: _____ If yes, are you interested in quitting?: ☐ Yes ☐ No

If former smoker, how much? _____ When did you quit? _____

Recreational Drug Use: ☐ Yes ☐ No How much/How often?: _____

Alcohol Consumption: ☐ Yes ☐ No How much/How often?: _____

Caffeine: ☐ Yes ☐ No Type/Amount/How often? _____

Exercise: ☐ Yes ☐ No Type/How Often? _____

Falls: Have you fallen within the last year? ☐ Yes ☐ No Were you injured? ☐ Yes ☐ No

Insurance Authorization

William Newton CARDIOLOGY

Please read the following information and sign this authorization to help us with filing your insurance.

I hereby authorize William Newton Cardiology to release any information relating to all claims for benefits submitted on behalf of me/or dependent(s) to any appropriate insurance carrier(s). I agree that my signature on this document authorizes my physician to submit claims for services rendered, without obtaining my signature on each claim submitted. I hereby assign to William Newton Cardiology and all providers therein, all payments of this authorization and assignment shall be considered as valid until the original is revoked.

Medigap assignment of benefits (Medicare patients only)
I hereby authorize William Newton Cardiology to release any information relating to all claims for benefits submitted on behalf of me to Medigap/secondary insurance company. I hereby assign William Newton Cardiology and all providers herein all payments for medical services rendered to be until it is revoked.

Acknowledgement of our Notice of Privacy Practices
I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the William Newton Cardiology Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the William Newton Cardiology Notice of Privacy Practices, effective 4/14/03, revised 2/1/13, revised 5/1/15.

Recording of office visits is prohibited
To ensure confidentiality and privacy, recording on any type of electronic device is strictly prohibited at any location within these offices. Thank you for your understanding and compliance.

Printed Patient Name: _____ Date: _____

Signature of Patient/Representative: _____ Date: _____

Physicians Pavilion | 1230 E Sixth Ave., Suite 2C | Winfield, KS 67156
Phone 620-222-6264 | Fax 620-800-1011

Consent to Communicate

William Newton CARDIOLOGY

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with William Newton Cardiology. This is NOT for access to your medical records. This form, when signed, allows William Newton Cardiology to communicate with the authorized person(s) regarding your personal information concerning insurance, benefits, payments, treatment, or other healthcare information regarding your care.

Patient Name: _____ DOB: _____

I hearby give my consent for William Newton Cardiology to communicate personal information on my behalf to the authorized person(s) named below. This authorization allows William Newton Cardiology to speak with the authorized individual(s) regarding the following: treatment, insurance claims, copays, or other aspects of care. I understand that this is limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named. I understand that it is my responsibility to let William Newton Cardiology know of any changes or to revoke this authorization. I may revoke this authorization at any time in writing to William Newton Cardiology. This authorization remains in effect for an unlimited amount of time unless revoked or updated. Any updated signed communication forms will supersede and replace all prior communication forms.

Person(s) authorized to speak with William Newton Cardiology.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Notice of Privacy Practices

William Newton CARDIOLOGY

Notice of Privacy Practices and Conduct of Conduct - Patient Acknowledgement

I hereby acknowledge that I have read and/or received a copy of William Newton Cardiology's Notice of Privacy Practice and Code of Conduct.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship of representative (if applicable): _____

Information Exchange
We have signed up to allow for data exchange with networks through the Interoperability Hub (Care Quality). This is a secure and confidential way to communicate your information to other providers that are involved in your health care.

I, _____, give William Newton Cardiology permission to provide information via Care Quality to my other providers that are involved in my care. I can rescind this consent at any time.

_____ _____
Patient Signature Date

Sunoh Artificial Intelligence Transcription
Consent Agreement:
I acknowledge that I have read and/or received a copy of the William Newton Cardiology Sunoh Artificial Intelligence Transcription service agreement, and hereby give my consent for the use of this service during my medical consultations at William Newton Cardiology. I can rescind this consent at any time.

_____ _____
Patient Signature Date