Himal Shah, MD **Huy Phan, MD** **Erica Balliet, NP-C**

1100 S. Dobson Rd, Suite A-105, Chandler, Arizona 85286

22707 S. Ellsworth Rd, Suite H-105, Queen Creek, Arizona 85242

Phone: (480) 289-4550 Fax: (480) 289-4551

Last Name: ______________________ First Name: _______________ MI: ______ Sex: ☐ M ☐ F

DOB: __________ SSN: ____________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Home: (____) ______________ Cell: (____) ______________ Work: (____) ______________

Address: ____

City: ______________________________ State: ______________ Zip: ______________

Primary Care Physician: ______________________________ Phone: (____) ____________

Referring Physician: _________________________________ Phone: (____) ____________

Employer Name: ______________________ City: __________ Phone: (____) ____________

Emergency Contact: ____________________ Relation: _______ Phone: (____) ____________

Primary Insurance: ____________________ Secondary Insurance: ____________________

Member ID: __________________________ Member ID: ___________________________

Group: _______________________________ Group: ______________________________

Claims Address: _______________________ Claims Address: ________________________

City: ________________________________ City: _______________________________

State: _____________ Zip: _____________ State: _____________ Zip: ______________

Pharmacy: _______________________________________ Phone: (____) ______________

Address: ______________________________ Cross Roads: __________________________

City: ___________________________ State: _______________ Zip: _______________

Signature: × _______________________________________ Date: ____________________

HEART & RHYTHM SOLUTIONS, LLC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Patient Date of Birth: __________________ **Patient Social Security Number:** ______________

Person(s) or Organization(s) authorized to receive/Disclose health information:

Person (s) or Organization authorized to receive/disclose information:

HEART & RHYTHM SOLUTIONS, LLC

1100 S. DOBSON RD SUITE A105

CHANDLER AZ 85286

480-289-4550 Fax: 480-289-4551

Specific description of the information that may be used or disclosed (including dates)

- Complete Medical Record
- Lab Reports
- Radiology Reports

I understand that this authorization will expire 1 year from date of signature.

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by written notification.

I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable).

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations the information described above may be redisclosed and would no longer be protected by these regulations.

Patient Guardian Name: ______________________________

Patient/guardian signature: ____________________________ **Date:** _______________

NOTE: You have the right to know specifically what information you are authorizing to release. You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release/receive information. You have the right to know who is going to use it or what it is going to be used for.

Heart & rhythm Solutions LLC

IMPORTANT SUMMARY NOTICE OF THE PRIVACY OF YOUR HEALTH INFORMATION

Patient Name: ________________________ **Patient DOB:** ___________________

Your Privacy is important to us. We record information about you so that we may provide you with quality medical care. We are committed to protecting this information. The notice of privacy practices describes your rights with regards to your health information, as well as we may use your health information. This is a summary of the more detailed information contained in your notice of privacy practices.

YOUR RIGHTS INCLUDE:

1. A right to amend your health information
2. A right to request restrictions on what information we use or how we disclose your health information
3. A right to see an accounting of certain disclosures we have made of your health information.
4. A right to obtain access to your health information with limited exceptions. (A notarized request, an appointment for access, appropriate advance notice, and a cost based fee for expenses is delineated by law).
5. A right to receive a paper copy of our notice of privacy practices

This right does have special restrictions and you may request and read the full notice at anytime. We may use your health information and/or records to:

1. Plan for your care and help your health care providers communicate and work together for you
2. Submit bills to pay for your care.
3. Help health care payers or medical insurance companies make sure services were provided.
4. Help improve the quality of your health care
5. Disclose information to certain officials or organizations as required by law.

Everyone who is trained or has access to your information is bound by your confidentiality requirements and signs a confidentiality agreement. We encourage you to read the notice and contact us if you need additional information.

I have received the Notice of Privacy Practices at Heart and Rhythm Solutions LLC

Patient/Guardian Signature: ________________________________ **Date:** _______________________

HEART & RHYTHM SOLUTIONS, LLC

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

Date: ________

OFFICE POLICY ON PAYMENT

All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18% annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed. The undersigned jointly and severally agree to pay all cost charged by the collection company, including a reasonable attorney fee.

OFFICE POLICY ON FAILED APPOINTMENTS

Failed appointments are significant contributor to rising health cost. Cancellation of appointment MUST BE RECEIVED 24 HRS PRIOR or a fee will be charged based on the length of the missed appointment.

INSURANCE POLICY

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to insurance carriers we are contracted with. Your are responsible for all co pays, deductibles and charges not covered by insurance. All other carriers are subject to payment at the time of service. Please understand that we cannot as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I hereby authorize payments directly to the business office of the physician for the medical and or surgical benefits in any, otherwise payable to me for services.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS;

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnosis, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for the release of the information.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT

Patient Name: ______________________________

Patient/Guardian Signature: ____________________