



74 Thomas Johnson Drive, Frederick, MD 21702
Phone (301)694-9033 Fax (301) 694-6204
Email: CardiologyAssociates74@gmail.com
Website: CardiologyAssociatesofFrederick.com

Providers

Hitesh V. Patel, M.D., F.A.C.C.

Sheel Y. Tolia, D.O., F.A.C.C.

Sunal S. Makadia, M.D., F.A.C.C.

Paresh K. Visana, P.A.-C

Our mission is to provide excellent cardiac care to better the lives of our patients. Our expectation is that each patient is provided exceptional service, personalized care, and to develop relationships with referring providers and patients to maintain lifelong cardiac health.

Thank you for choosing Cardiology Associates for your cardiac needs.

In order to help make your upcoming office visit as easy as possible, we have enclosed necessary forms which should be completed **prior** to your arrival. We recommend that you personally deliver, fax, e-mail or mail the forms back to us.

Please also bring:

- **Insurance Cards**
- **Photo Identification**
- **Form of payment** (We accept cash, check, debit card, MasterCard, Visa & American Express)
- A list of all the medications you are currently taking
- Any medical records, blood lab work, and diagnostic testing that you may have done as it pertains to your visit. Feel free to drop these off at the office prior to your visit.

If you are bringing records in-person, **please give all records to the medical assistant when they are preparing you to see the doctor.** We will electronically scan these documents and return them to you. Following these instructions will greatly facilitate your visit.

We very much value our patients' time and will work to minimize your wait in our office.

Our hours of operation and other useful information are available on our website at CardiologyAssociatesofFrederick.com. If you have any questions or need to verify the location, please call our friendly staff.

We look forward to meeting you soon, and thank you for choosing us for your cardiac care!

Sincerely,

The Cardiology Associates of Frederick Team



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Patient Information

(Please print clearly)

Patient's Name (Last) _____ (First) _____ (MI) _____
Nickname _____ Email _____
Sex M F Date of Birth ___/___/___ SS # _____
Address _____ APT # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Primary Language* _____ Marital Status: M / S / D / W (please circle)
Race* _____ Ethnicity* Hispanic or Latino/ Not Hispanic or Latino (please circle)
* Requested under federal guidelines for "Meaningful Use" to optimize patient-specific treatment and counseling

Emergency Contact _____ Relationship _____ Phone _____
May we discuss your medical condition with another person? Yes No
If Yes, Whom _____ Relationship _____
Primary Care Provider _____ Phone _____
Did a doctor refer you to us? If yes, Doctor _____ Phone _____
Preferred Pharmacy _____ Location _____
How did you hear about us? _____

Responsible Party (Complete only if the patient is a minor/dependent)

Guarantor Name _____ Relationship to Patient _____
Home Phone _____ Cell Phone _____ Work _____
Address _____ APT # _____
City _____ State _____ Zip _____
Guarantor SS # _____ Guarantor DOB ___/___/___ Sex M F
* We do not bill absent parents; the adult presenting the patient for care is the responsible party.

I hereby certify the above information to be true and correct to the best of my knowledge. I understand that I am responsible to pay for all services rendered to me, I grant permission to my physician to mutually exchange medical information with referring physician and/or associates. I hereby authorize disclosure of my medical records to my insurance carrier to obtain reimbursement.

Signature: _____

Date: _____



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Authorization for the Release of Protected Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____

I authorize representatives from Cardiology Associates to release or obtain the health information as directed below:

Self (Patient)
Obtain from/ Release to:

Facility: _____

Address: _____

Phone Number: _____

Fax Number: _____

Release to/ Obtain from:

Cardiology Associates of Frederick
74 Thomas Johnson Drive
Frederick, MD 21702
Phone (301) 694-9033 Fax (301) 694-6204

This request applies to:

- All healthcare information.
- Healthcare information relating to the following treatment, condition, or dates:

- Other: _____

Signature: _____ Date: _____



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Authorization to Release Medical Information

Patient Name: _____
Date of Birth: _____ Phone: _____

**I authorize Cardiology Associates to release my medical information to another person/
family member.**

(This is separate from Emergency Contact and also does not include Doctors, see
previous page for Medical Release)

Yes or No (If Yes) Name: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

Relationship: _____ Phone Number: _____

Signature: _____

Date: _____



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Payment Policy

Thank you for choosing Cardiology Associates as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments, coinsurance, and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a Collection Agency, a \$100.00 collections processing fee will be added to any outstanding balance.
- 3. Referrals.** It is your responsibility to know if you require a referral for your insurance policy and to provide it to us at the time of service. If you are seen and do not provide a referral you will be responsible for the claim balance.
- 4. Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- 5. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 6. Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
- 7. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Our practice is committed to providing the best treatment and care to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines.

For additional information or questions about this policy please contact:

Cardiology Associates Monday – Friday 8:30am-5pm

Signature: _____

Date: _____



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Name: _____ Date of Birth: _____

Doctor that referred you to Cardiology Associates: _____

Do you have a previous cardiologist? **YES NO** If yes, please list their name: _____

Cardiologist Phone: _____ If known, please list the date of last apt: _____

What is the reason for your visit today? _____

Please list any medication allergies:

Reaction to Medication:

Other Allergies: _____

Do you take any medications? **YES NO**

Please list all medication (s) including dosage (prescription, over-the-counter, and herbal): _____

Please list all significant medical history: _____

Please list all prior surgeries including the year: _____

Name: _____ Date of Birth: _____

WOMEN: Please complete the following:

Number of Pregnancies: _____

Number of Cesarean Sections: _____

Number of Vaginal Deliveries: _____

Are You Currently Pregnant? **YES NO**

Do you take prescription blood thinners? **YES NO**

Do you take aspirin or anti-inflammatory medicines every day? **YES NO**

Have you had a heart valve replacement? **YES NO**

Have you have a catheterization? **YES NO**

Have you had CABG? **YES NO**

Are you allergic to latex? **YES NO**

Are you allergic to intravenous contrast (dye)? **YES NO**

Social History

Current Marital Status: S M W D

Occupation: _____

Do you use tobacco products: **YES NO**

Do you drink alcohol: **YES NO**

Type: _____

Beer Wine Liquor

Packs/day: _____

Daily Weekly Monthly Socially Rarely

How many years? _____

Amount: _____

Tried to quit? _____

Last Drink: _____

Years since quitting? _____

Passive smoke exposure? _____

Do you have and Advance Directive: **YES NO**

Do you have a family history of any of the following: **(Circle all that apply)**

Blood Disease

Hyperlipidemia

BPH (Prostate Enlargement)

Inflammatory Bowel Disease

Seizure Disorder

Renal Failure

Thyroid Disorder

Hypertension (High Blood Pressure)

Urinary Tract Infections

Cerebrovascular (Stroke)

Migraines

Cancer: Type 1. _____

Eczema

2. _____

Diabetes

Which Family Member 1. _____

Coronary Artery Disease

2. _____

Other: _____

Name: _____ Date of Birth: _____

Review of Systems

Constitutional

Change in Appetite YES NO
Chills YES NO
Fatigue YES NO
Fever YES NO

Eyes

Blurred vision YES NO
Changes in vision YES NO

ENT

Headaches YES NO
Nasal congestion YES NO
Runny Nose YES NO
Sinus pain YES NO
Sore throat YES NO

Cardiovascular

Cardiac murmurs YES NO
Chest pain with exertion YES NO
Chest pain at rest YES NO
Irregular heartbeat YES NO

Respiratory

Painful respiration YES NO
Shortness of breath YES NO
Wheezing YES NO

Gastrointestinal

Abdominal pain YES NO
Blood in Stool YES NO
Diarrhea YES NO
Loss of appetite YES NO
Nausea YES NO

Vomiting YES NO

Allergic-Immunologic

Allergic Dermatitis YES NO
Frequent Illness YES NO
Sinus Allergy Symptom YES NO

Genito-Urinary

Dysuria (painful urination) YES NO
Frequency of urination YES NO
Impotence YES NO
Nocturia (frequent urination at night) YES NO

Neurological

Headaches YES NO
Gait Abnormality YES NO
Numbness of tingling sensation YES NO
Seizures YES NO

Musculoskeletal

Back pain YES NO
Joint pain YES NO
Muscle pain YES NO

Endocrine

Cold intolerance YES NO
Excessive thirst YES NO
Excessive urination YES NO
Heat intolerance YES NO
Weight gain YES NO
Weight loss YES NO

Hematology/Lymphatic

Easy bleeding YES NO
Easy bruising YES NO

