Prairie Cardiovascular
The Doctors of Prairie

CONSENT FOR TREATMENT

Patient Name_____ _____ _____
(Last) (First) (Middle) Social Security # Date of Birth

I. MEDICAL CARE REQUEST AND AUTHORIZATION

I understand that I may have a condition which requires medical care. I am requesting and authorizing medical care by Prairie Cardiovascular Consultants, Ltd. ("Prairie"), any of the physicians associated with Prairie and other health professionals who are associated either with Prairie or the facility at which the medical care is rendered who Prairie considers reasonably necessary for my care. I agree to their participation in my care.

I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care.

I understand that unforeseen conditions may arise during the rendering of my medical care and I hereby authorize Prairie and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives and to provide any such directives for my physicians and health care providers to be aware of and rely on.

I understand that I may revoke this request and authorization for medical care at any time by written notice to Prairie.

I understand that Prairie Cardiovascular Consultants, Ltd. is a personal service corporation and that Residents, Fellows, and medical students may assist in providing my care and that my medical records may be used for purposes of education and patient care by these individuals. I acknowledge and consent to designated observers being present, unless I have requested otherwise.

II. RELEASE OF MEDICAL INFORMATION CONSENT

I consent to the development, use and disclosure of medical information about me as noted in the next paragraph.

Prairie and any person or entity designated by it may develop, use and disclose medical information about me (i) for my treatment and to other physicians, health professionals or entities who may be involved in my care; (ii) to obtain payment for treatment by billing and performing any other functions necessary to obtain reimbursement for care delivered to me, including collections of such payments from me by collection agencies or attorneys; and (iii) to support Prairie's health care operations such as analyzing, monitoring and comparing patient data to improve treatment methods and for corporate compliance functions. In addition, Prairie may use or disclose medical information about me for research studies, funeral arrangements, organ and tissue donation, workers' compensation, emergencies and all uses and disclosures that are permitted or required by the laws of the State of Illinois or federal laws without my consent.

As a service to our patients, Prairie provides a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

This consent permits disclosure of information and reports in my file; HIV/AIDS, Mental Health, Drug/Alcohol Abuse, STD's, Developmental Disabilities and Genetic Testing Results, if any.

III. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

HIPAA (Health Insurance Portability and Accountability Act) is a federally mandated law. It provides guidelines to health care providers about the privacy of my medical information and requires Prairie to inform me of its privacy policies.

I acknowledge that I have received a copy of Prairie's Notice of Privacy Practices. It describes how my medical information may be used within Prairie, how it can be disclosed outside of Prairie, how I may access my medical information and my rights with regard to

Notice of Privacy Practices

(Effective: September 23, 2013)

Prairie
CARDIOVASCULAR CONSULTANTS, LTD.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.

The **Health Insurance Portability and Accountability Act (HIPAA) is a federally mandated law.** It provides guidelines to health care providers about the privacy of your medical information and requires us to inform you of our privacy policies.

This privacy notice, provided by Prairie Cardiovascular Consultants, Ltd. (Prairie), is to inform our patients, in compliance with the HIPAA law, about the uses and/or disclosures and rights pertaining to their medical information. You may be asked to acknowledge in writing your receipt of this notice.

An audio version of the Notice of Privacy Practices is available at 217-757-6585.

Medical information is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health condition and related health care services or the payment for such services.

Who We Are

We are a network of clinical providers: physicians, nurses and medical professionals, in Illinois working together as part of the Hospital Sisters Health System (HSHS). Our medical professionals support the Mission of HSHS, which is dedicated to compassionate, holistic health care that treats the whole person, in the spirit and tradition of our founding Hospital Sisters of St. Francis.

Our pledge to you

We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care, to share with other physicians and hospitals involved with your care, and to comply with legal requirements. This notice applies to all of the records of your medical care that we maintain, whether created by Prairie physicians and staff, your family doctor or other health care professionals. These other physicians and health care professionals may have different policies or notices regarding their uses and disclosure of medical information.

How we may use and disclose medical information about you

We may use and disclose medical information about you without your prior authorization:

- **For treatment** (such as sending medical information about you to physicians, nurses, technicians, pharmacies, medical students, support staff, medical records, laboratories, transcriptionists, home health agencies, visiting nurses, hospitals, and ambulance companies).
- **To obtain payment for treatment** (such as sending billing information to your insurance company, Medicare, other third party payers, collection agencies, and/or a family member that is helping you pay for your health care).
- **To support our health care operations** (such as comparing patient data to improve treatment methods, audit functions, and monitoring quality care).

We may use or disclose medical information without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without your prior authorization for **public health purposes, abuse or neglect reporting, health oversight activities, government functions, research studies, funeral arrangements, organ and tissue donation, worker's compensation, and emergencies.** We may disclose medical information when **required by law**, such as in response to judicial or administrative orders.

We may contact you about the following:

- **Potential treatment** options,
- Health related benefits and services,
- To support internal **fundraising** with an opportunity to opt out**,** and
- Your satisfaction with our services.

We may contact you for **appointment reminders**, to schedule medical services, to inform you of **test results,** and **payment status**.

We may disclose medical information about you to **a friend, family member or other person** who is involved in your medical care. We may do so by mail, telephone and other methods, including leaving information on an answering machine. We may disclose medical information about you to **disaster relief authorities** so that your family can be notified of your location and condition.

We will use our professional judgment in determining what we disclose and to whom, based on our evaluation of your best interests.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you, such as, marketing and sales purposes. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision except to the extent those disclosures have already been made based upon your original authorization.

Your rights regarding medical information about you

In most cases, you have the **right to view and/or obtain a copy either in paper or electronic format** of medical information in a designated record set that we use to make decisions about your care by submitting a written request. We may charge a reasonable, cost-based fee for the cost of copying, mailing or other expenses. If we deny your request to view or obtain a copy in paper or electronic format, you may submit a written request for a review of that decision.

If you believe information in your record is incorrect or if important information is missing, you have **the right to request we amend the records** by submitting a request in writing that provides your reason for requesting the amendment. We may deny your request if the information was not created by us, if it is not part of the medical information maintained by us, or if we determine the record is accurate. You may appeal, in writing, our decision to deny your request.

You have the **right to receive a list** of disclosures of medical information for reasons other than treatment, payment, health care operations or where you specifically authorize a disclosure, by submitting a written request. The request must state the time period desired for the list, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper form. The first disclosure list request in a 12-month period is free; other requests may be subject to a fee. We will inform you of the cost before you incur any costs.

You have the **right to obtain additional copies** of the Prairie Notice of Privacy Practices upon request.

If this Notice was sent to you electronically, you have the right to a paper copy.

You have the **right to request medical information about you be communicated** to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. We will accommodate all reasonable requests.

You have the right to **request in writing restrictions** on uses and disclosures of medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you or for notification purposes. You have the **right to restrict certain disclosures of your medical information to a health plan, in writing, for a service paid in full or out of pocket**. You may not limit the uses and disclosures we are legally required or allowed to make.

You may be notified of any breach of confidentiality within 60 days of discovery of the breach. The notification will include a brief description of the breach and the information disclosed, steps you should take to protect yourself from harm, and a contact person to obtain additional information.

All **written requests or appeals** concerning your rights to medical information should be submitted to the HIPAA Privacy Office listed at the end of this notice.

Who will follow this notice?

Prairie provides health care to our patients in partnership with physicians and other professionals and organizations. The privacy practices in this notice will be followed by:

All employees of our organization, including staff at our affiliate sites with whom we may share information.

Any Business Associates of Prairie with whom we share medical information.

We are required by law to:

Take reasonable measures to keep medical information about you private.

Give you this notice of our legal duties and privacy practices with respect to medical information about you.

Follow the terms of the notice of privacy practice that is currently in effect.

Changes to this Notice

We may make changes to our privacy practices at any time. Changes will apply to medical information we already maintain, as well as medical information obtained after the change. If we make a significant change in our privacy practices, we will post a new Notice of Privacy Practices in waiting room areas. You can request a copy of a current Notice of Privacy Practices at any time. The effective date is listed on the cover.

Questions or Complaints

If you are concerned your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our HIPAA Privacy Office or you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our HIPAA Privacy Office can provide you the address. You will not be penalized or retaliated against for filing a complaint in good faith.

If you have any questions, please contact our HIPAA Privacy Office at the address, phone number, or E-mail address listed below.

Prairie Cardiovascular Consultants, Ltd.
HIPAA Privacy Office
619 East Mason Street- Suite 4P57
PO Box 19420
Springfield, Illinois 62794-6420
217-788-0706
HIPAA2@prairieheart.com

Form #327 3-17-10, 6-6-2013, 8-9-2013

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my medical information. Prairie reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a copy of a current Notice of Privacy Practices at any time.

IV. FINANCIAL AGREEMENT

I understand that I am personally responsible for charges incurred for medical care rendered by Prairie. I understand that Medicare, insurance companies, my employer and other payers may have restrictions on reimbursement for medical care rendered by Prairie. These restrictions may include pre-certification, use of designated facilities, frequency of tests performed, non-covered services, deductibles, co-payments and other requirements. I understand that it is my responsibility to comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payers.

I certify that all information given by me in applying for payment by Medicare, if applicable, is correct. I understand it is mandatory to notify Prairie of any other party who may be responsible for reimbursement of my medical care. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I certify that all information given by me to bill Medicare, insurance companies, my employer and other payers is correct and complete. I understand that payers may have time limits for filing claims and providing incorrect and/or incomplete information may result in denial of reimbursement for which I will be personally responsible.

I acknowledge that should it be necessary for Prairie to refer my account to external sources for collection, I will pay a twenty-seven percent collection fee, attorney's fees and court costs that are incurred by Prairie. I acknowledge these fees are reasonable and in addition to my balances due Prairie. I agree that any credit balances resulting from payments by insurance companies, employers, myself and others may be applied against any other balances due by me or family members.

I authorize all payments for medical care rendered to me by Prairie to be assigned, transferred and paid directly to Prairie. I will remit to Prairie immediately the full amount of any payments that may be received by me, a family member or custodian from Medicare, an insurance company, my employer or any payer for medical care rendered to me by Prairie.

I hereby release Prairie from any and all legal responsibilities or liabilities relating to my financial responsibilities.

I acknowledge that I understand all of the above and agree to abide by the terms of this document.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name of Patient or Guardian Relationship to Patient

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PATIENT INFORMATION FORM

(New Patient or New Consult for Prior Patient)

We thank you in advance for taking the time to complete this information. This will assist your physician in providing the best care for you.

Name: _____ DOB: _____ Date: _____

Gender: _____ Age: _____ Phone: _____

Primary Care/Family Physician: _____

What is the reason for today's visit? Please list any problems that you are experiencing.

_____

_____

_____

Medications (Please list the name, dose & how often or attach a current printed list if you have one)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies (Please list your allergies.)

_____ _____ _____

Are you allergic to X-ray dye? ___Yes ___No Please explain: _____

Risk Factors

1.) Do you smoke? ___Yes ___No
- If yes, how many packs per day? _____ For how many years? _____
- If no, did you ever smoke regularly? ____ When did you stop? _____

What other tobacco products do you use besides cigarettes? _____

2.) Do you have diabetes? ____Yes ____No
If so, for how long? _____ Do you take medications for your diabetes? _____

3.) Have you ever been told that you have high blood pressure? ___Yes ___No
If so, how long ago were you told? _____

4.) Do you have a family member (father, mother, brother, sister) that has had a heart attack, a stent, heart bypass surgery or a stroke? If so, who and at what age? _____
_____
_____
_____
_____

5.) Have you ever been told that you have high cholesterol? ___Yes ___No
If so, has your high cholesterol ever required cholesterol medication?___Yes ___No
If so, please explain: _____
_____

"FOR FEMALES ONLY"

1.) At what age did you have your last menstrual period? _____

2.) Have you ever taken hormone replacement therapy (estrogen)? ___Yes ___No
If so, when and what type? _____

3.) Have you had a hysterectomy? ___Yes ___No Explain: _____

Please check any items below that pertain to your cardiovascular history:

☐ Heart attack (date: _____)

☐ Congestive heart failure (date: _____)

☐ Heart rhythm abnormalities

☐ Murmur

☐ Childhood heart defects

☐ Peripheral vascular disease

☐ Stroke (CVA) (date: _____)

☐ Transient ischemic attack (TIA) (date: _____)

Please check any of the procedures below that you have had:

Procedure	Date (if known)	Procedure	Date (if known)
☐ 1) Heart catheterization	_____	☐ 7) Stents in vessels other than the heart	_____
☐ 2) Balloon/stent of heart	_____	☐ 8) Pacemaker	_____
☐ 3) Heart bypass surgery	_____	☐ 9) Internal defibrillator (ICD)	_____
☐ 4) Heart valve surgery	_____	☐ 10) EP (electrophysiologic study)	_____
☐ 5) Carotid artery surgery	_____	☐ 11) Colonoscopy	_____
☐ 6) Leg vein bypass surgery	_____		

Please complete the following information regarding your general medical/surgical history.

Check items below that pertain to you:

☐ Anemia	☐ Arthritis	☐ Asthma
☐ Bleeding disorder	☐ Blood clots	☐ History of blood transfusions
☐ Bowel disorders	☐ Cancer	☐ Emphysema/COPD
☐ Esophageal reflux(GERD)	☐ Gallbladder disease	☐ Glaucoma/cataracts
☐ Gout	☐ Hepatitis	☐ Hormone replacement
☐ Kidney disease/stones	☐ Liver disease/jaundice	☐ Lung disease
☐ Migraines	☐ Pancreatic disease	☐ Pneumonia
☐ Prostate problems	☐ Rheumatic fever	☐ Seizures
☐ Sleep apnea	☐ Stomach/colon cancer	☐ Thyroid problems
☐ Tuberculosis (TB)	☐ Ulcers	☐ Vein problems/stripping

Other: (Please explain): _____

_____

Please list any surgeries, tests or illnesses not mentioned on prior page:

Significant surgery/illness/injuries	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History

1.) What is your occupation? _____

2.) What is your marital status? _____

3.) How many children do you have? _____

4.) Do you exercise? ___Yes ___No
If so, how often? _____

5.) Are you on a special diet? ___Yes ___No
If so, please describe: _____

6.) Do you use caffeine? ___Yes ___No
If so, how much? _____

7.) Do you drink alcoholic beverages? ___Yes ___No
If so, how much? _____

8.) Do you use recreational street drugs? ___Yes ___No
If so, please explain: _____

Review of Systems: Please circle all items that pertain to you or circle NO PROBLEM.

General: NO PROBLEM **OR** Weight gain Weight loss Fatigue
Other _____

Skin: NO PROBLEM **OR** Rash
Other _____

Eyes: NO PROBLEM **OR** Recent changes in vision or vision loss
Other _____

Ears, nose & throat: NO PROBLEM **OR** Recent changes in hearing or hearing loss
Other _____

Heart & blood vessels: NO PROBLEM **OR** Palpitations Chest Tightness/Discomfort/Pain
Passing out/fainting Shortness of breath
Swelling in feet or ankles Calf pain when walking
Other _____

Breathing & lungs: NO PROBLEM **OR** Snoring Chronic cough Coughing up blood
Other _____

Stomach/digestion: NO PROBLEM **OR** Dark/tarry stools Bleeding from rectum
Other _____

Urinary: NO PROBLEM **OR** Painful urination
Other _____

Muscles/bones: NO PROBLEM **OR** Joint stiffness or joint pain
Other _____

Hormonal: NO PROBLEM **OR** Intolerance to heat or cold Excessive hunger or thirst
Other _____

Nerves/pain: NO PROBLEM **OR** Numbness Tingling Weakness of Extremities
Other _____

Bleeding problems: NO PROBLEM **OR** Easy bruising or bleeding
Other _____

Other complaints: _____

Patients: Please do not fill out this page. Your physician/staff will complete this page.

Name: _____ **DOB:** _____ **Date:** _____

Age: _____ **Phone:** _____

Primary Physician: _____

Chief Complaint: _____

History of Present Illness: _____

_____

_____

_____

_____

_____

PE: Temp: _____ Height: _____ Weight: _____ Pulse: _____ Reg/Irreg Resp: _____

Waist circumference: _____

Blood Pressure: L:_____ R: _____

☐Normal
Neck:
CV:
Lungs:
Abdomen:
Ext: ☐ No edema ☐ 1+ ☐ 2+

	Brachial	Radial	Femoral	Popliteal	DP	PT
Right			☐Bruit			
Left			☐Bruit			

Plan: _____

_____

_____

Date: 02/27/06