ADVANCED CARDIOVASCULAR SPECIALISTS

Carlos E. Fonte, M.D., FACC, FACP, FSCAI

3201 S. Maryland Parkway, Suite 502,
Las Vegas, NV 89109
ph: (702) 733-8600 fax: (702) 733-0374

Last Name_____ First Name_____ M.I._____

Date of Birth_____ Age_____ Sex: M / F

Current Address_____

City_____ State_____ Zip Code_____

Home phone_____ Cell_____ Work phone_____

Occupation_____ Employer_____

Social Security #_____ Marital Status_____ Spouse's Name_____

Spouse's Employer_____ Spouse's Work #_____

Referring doctor:_____

Insured's Information IF OTHER than patient:

Last Name_____ First Name_____ M.I._____
Date of Birth_____ Age_____ Sex: M / F Relationship to Patient _____
Social Security #_____ Employer_____

In case of an emergency, list a relative or friend to contact NOT residing with you:
Name_____ Phone_____ Relationship_____

INSURANCE INFORMATION:

Primary Insurance_____ Phone #_____
Insurance Address_____
Group #_____ I.D. #_____ Copay $_____

Secondary Insurance_____ Phone #_____
Insurance Address_____
Group #_____ I.D.#_____ Copay $_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay for me and family members shown by statements promtply upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, we agree to pay reasonable attorney's fees or other costs as the court determines proper. I further agree to pay 100% of the collection agency fees should collection actions become necessary. I authorize the release of any medical information necessary to process this claim for additional services.

SIGNATURE_____ DATE_____

ADVANCED CARDIOVASCULAR SPECIALISTS

ph: (702) 733-8600 fax: (702) 733-0374

To: _____

_____

_____

_____

Please release any and all medical records to:

ADVANCED CARDIOVASCULAR SPECIALISTS

Carlos E. Fonte, M.D.

Fax to: (702) 733-0374

or

Mail to: 3201 S. Maryland Parkway
Suite - 502
Las Vegas, NV 89109

_____
Please print patient name

_____
Patient signature

_____
Patient date of birth

_____
Patient social security #

_____
Witness

_____
Date

ADVANCED CARDIOVASCULAR SPECIALISTS

As a courtesy, we will be happy to bill your insurance for you. However, please be aware of the following:

1. **You are ultimately responsible for payment in full for all services.** At the time services are rendered, you will be requested to pay the estimated co-payment, and, or percentage indicated by your insurance plan.

2. It is your responsibility to know your policy. Although we do maintain contracts with many insurance companies, there are insurance companies that we are NOT contracted with. If we are not contracted with your insurance company, please be aware that your benefits could significantly change, or benefits could be denied entirely. You can call our billing department if you need to know what your percentage will be.

3. Most insurance companies have annual deductibles which you are required to pay before charges are submitted to them and are eligible for payment.

4. If your insurance company requires authorization for service, **you are ultimately responsible to be sure the authorization has been obtained by our office.** Without authorization, please be advised that your insurance company could deny payment, rendering you with full obligation of payment.

5. It is our policy to allow ninety (90) days for reimbursement by your insurance company for all services rendered, once the claim has been submitted on your behalf. For whatever reason, if this 90 day period is exceeded and reimbursement is not received, you will be required to pay the balance in full.

6. Should you not be able to keep an appointment, you must notify us within 24 hours. **Otherwise, a $25.00 fee will be billed to you if you fail to keep your appointment. This is a fee that the *patient* will be responsible for since this charge is not billable to your insurance.**

Please help us provide your insurance company with everything they need to process your claim in a timely manner. If you have any questions, please do not hesitate in talking to our billing office.

I HAVE READ AND UNDERSTAND THE ABOVE:

Signed: _____ Date: _____

ADVANCED
CARDIOVASCULAR
SPECIALISTS

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Patient's Name_____ Date_____

Referring Doctor_____

Reason for visit_____

Past Medical History (list all major illnesses, hospitalizations, operations)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Family History: Heart disease - Y/N Hypertension - Y/N Diabetes - Y/N

Do you smoke?_____yes_____no
How many packs per day?_____

Drink alcohol?_____yes_____no
How many drinks per day?_____

Previous heart procedures / tests? When?

Treadmill_____ Echocardiogram_____ EKG_____
Angioplasty_____ Stent_____ Bypass_____
Pacemaker_____ Defibrillator_____

Allergies (list all medication allergies)

_____ _____ _____
_____ _____ _____

Current Medication: (name, dose, frequency, including birth control, supplements, pain medications)

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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Advanced Cardiovascular Specialists

Carlos E. Fonte, M.D. F.A.C.C. F.S.C.A.I.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. Should I so chose I may request a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Attached I will find Medical Release Form on which I will state my preferences on how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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Las Vegas, Nevada 89109
Phone: (702)733-8600 Fax:(702)733-0374
www.carlosfontemd.com

Medical Information Release Form

(HIPPA Release Form)

Name: _____ Date of Birth : ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis , records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child (ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

[ ] Do you have a Durable Power of Attorney (DPOA) for health care ? Y or N

This **Release of information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number : _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (Day) _____ between (time) _____

Signed : _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Advanced Cardiovascular Specialists

Carlos E. Fonte, M.D. F.A.C.C. F.S.C.A.I.

Patient: _____ **Date of Birth**_____

Due to the complexity of medicine and medications, the following personal data is being requested in order to make your patient files complete.

Basic Language:

___ English ___ Spanish ___ French ___German ___Italian ___Other

Ethnicity:

Hispanic or Latino ( ) Yes ( ) No

Race:

___ American Indian/Alaska Native ___ Black/African American

___ Native Hawaiian/Other Pacific Islander

___ Caucasian/White ___Asian ___ Undetermined

Pharmacy Name/Address or Cross Street_____

Pharmacy Phone#_____

Patient Consent for RX History _____Yes _____ No

Patient Signature _____

Advanced Cardiovascular Specialists

Carlos E. Fonte, M.D. F.A.C.C. F.S.C.A.I.

Express Written Consent

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing service as applicable.

I/We have read this disclosure and agree that the Advanced Cardiovascular Specialists or their agents may contact me/us as described above.

Patient Signature Date

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Fax (702) 733-0374

653 Town Center Drive #506
Las Vegas, NV 89144

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