Mecklenburg Heart
SPECIALISTS, PA

Board Certified in Diagnostic and Invasive Cardiology

Aamer A. Qureshi MD, FACC, FSCAI
Stephanie Baumann PA-C

2711 Randolph Rd, Suite 305
Charlotte, NC 28207
Phone: (704) 334-0600
Fax: (704) 334-0615

We would like to take this opportunity to welcome you to Mecklenburg Heart Specialists. Our goal is to provide you with excellent medical care in a friendly, caring atmosphere. In order to allow our doctors the appropriate amount of time for each patient, please have the following information completed prior to your appointment and bring the finished forms with you. Appointments may need to be rescheduled if additional time is taken for completion of these forms in our office.

- New Patient Evaluation
- Patient Information Sheet
- Acknowledgement of review of notice of privacy practices

(Above copy will be provided in office)

- Authorization for release of information
- Authorization to release/forward records

If your insurance requires a referral from your primary care physician, please ask their office to contact us with this information. Your appointment may need to be rescheduled if we do not receive a referral prior to your coming to our office. Please bring your insurance cards and co-payment with you to your appointment, as we will collect these at check-in.

Our office hours are 8:30am to 5:00pm Monday through Thursday, and 8:30am to 3:00pm on Friday. If you have any questions, please don't hesitate to call. If you find you need to change your appointment, please call us at your earliest opportunity. We will be calling you two days prior to your appointment to confirm your visit and to answer any last minute questions.

Once again, we look forward to seeing you and getting acquainted.

Sincerely,

Aamer A. Qureshi, MD

Stephanie Baumann, PA-C

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Directions to our office in the Eastover Building:

You may access our office either from Randolph Rd., directly across from The Mint Museum, or from 7th Street, across from the old fire tower.

Randolph Rd – toward uptown

From Wendover Rd. intersection
Go down Randolph Rd. 1.1 miles
Cross over bridge
Turn right into Eastover Medical Park
Go straight over 2 speed bumps
Suite 305 will be on your left (at the front)

E. 4th St. / Randolph Rd. – from uptown

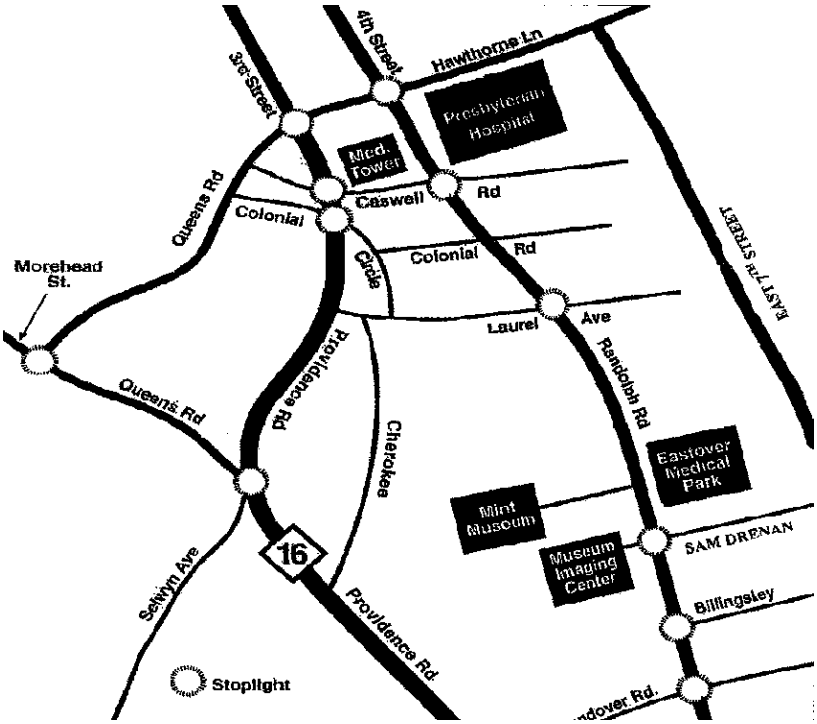
From Hawthorne Lane intersection
Go down East 4th / Randolph Rd. for 1.1 miles
Turn left into Eastover Medical Park
Go straight over 2 speed bumps
Suite 305 will be on your left (at the front)

Monroe Rd. – East 7th Street toward uptown

From Wendover Rd. intersection
Go up Monroe Rd./E 7th St. 1.1 miles
Turn left into Eastover Medical Park
Go straight over 3 speed bumps
Go across the connector bridge
Suite 305 is in the front

7th St. from uptown

From Hawthorne Lane intersection
Go down East 7th St. for about 1.1 miles
Turn right into Eastover Medical Park
Go straight over 3 speed bumps
Go across the connector bridge
Suite 305 is in the front



Mecklenburg Heart
SPECIALISTS, PA

New Patient Evaluation

Name:	Date of Birth:	Today's Date:	
Occupation:	Marital Status: M S W D	Age:	Sex: M / F

Reason for Appointment:

Medication Allergies:

Current Medications:

Family History			
Mother:	Alive Deceased	Age	Health Problems/ Cause of Death
Father:	Alive Deceased	Age	Health Problems/ Cause of Death
Brothers:	# Living:		Health Problems
	# Deceased:		Cause of Death
Sisters:	# Living:		Health Problems
	# Deceased:		Cause of Death

Does anyone in your extended family have: □Heart Disease □High Blood Pressure □Diabetes □Stroke

Do you have any children? Y / N

# Living	List any serious illnesses they have:
# Deceased	Causes:

Personal History:		
Hospitalizations: (surgery/illnesses/procedures)		
Year	Reason	Hospital

Have you ever had any of the following?: (Check all that apply)			
○ Heart Disease ○ High Blood Pressure ○ Heart Murmur ○ Rheumatic Fever ○ Enlarged Heart ○ Heart Attack	○ Irregular Heartbeat ○ Diabetes ○ Stroke ○ Shortness of Breath ○ Chest Pain ○ Indigestion	○ Pneumonia ○ Stomach Ulcer ○ Cancer ○ Seizures ○ Fainting Spells ○ Pleurisy	○ Phlebitis ○ Thyroid Problems ○ Swelling of Feet/Legs ○ Leg Pain

Personal Habits:		
Do you exercise regularly?	Y / N	How much?
Do you smoke?	Y / N	How many packs per day?
Did you ever smoke?	Y / N	How many years and when did you quit?
Do you drink alcohol?	Y / N	How many drinks per day?
Do you use illegal drugs?	Y / N	What kind?

Mecklenburg Heart
SPECIALISTS, PA

PATIENT INFORMATION		CHART#		
NAME(LAST)		FIRST	MI	
ADDRESS		CITY	STATE	ZIP
BIRTHDATE	SS#	SEX M / F	MARITAL STATUS M S W D	
HOME PHONE		WORK/CELL PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		
EMPLOYER		SPOUSE'S NAME		

EMERGENCY CONTACT (not living with you)	
NAME	RELATIONSHIP TO PATIENT
HOME PHONE	WORK/CELL PHONE

TO OUR PATIENTS: This form gives us your consent for treatment and permission to send copies of your medical records to your referring physician and to the insurance companies processing your claims. Any other outside agency requesting your records much submit a specific authorization signed by you, with each and every request.

CONSENT FOR ROUTINE TREATMENT: I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as my physician(s) or Mecklenburg Heart Specialists considers being necessary. I understand that it is the policy of Mecklenburg Heart Specialists (except in emergency situations) that no substantial tests or procedures are performed upon me unless and until I have an opportunity to discuss them with my physician(s) to my satisfaction. I understand that I have the right to consent or refuse consent to any proposed test, procedure or therapeutic course.

INSURANCE/MEDICARE: I authorize any holder of medical or other information about me to release to insurance carriers the Social Security Administration and Health Care Financing Administration (or its intermediaries or carrier) any information needed for this or a related insurance and/or Medicare claim. I hereby assign to the physicians all payments for hospital/medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance. I understand that Mecklenburg Heart Specialists accepts assignment for Medicare claims and all regulations pertaining to Medicare assignment and benefits apply.

RELEASE OF MEDICAL RECORDS: I hereby authorize Mecklenburg Heart Specialists to release copies of any and all information in my medical records including information (if present) concerning a chemical dependency problem and treatment (drugs and alcohol), psychological or psychiatric diagnoses and treatment, sickle cell anemia and/or HIV tests, results and treatment (AIDS). I understand that this release will remain valid until revoked in writing by me. I release Mecklenburg Heart Specialists, its employees and all others caring for me at Mecklenburg Heart Specialists from any liability connected with the use of these records or the information in them by anyone outside of Mecklenburg Heart Specialists.

I have read (or had read to me) all of the above and understand all parts of this authorization.

_____ _____

Patient Signature Date

Aamer A. Qureshi MD, FACC, FSCAI
Stephanie Baumann PA-C

2711 Randolph Rd, Suite 305
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Authorization for Release of Information

Name of Patient:_____ Date of Birth:_____

MECKLENBURG HEART SPECIALISTS is authorized to release protected health information about the above named in the following manner and to the identified persons listed below.

List each person/entity to receive information and verify the type of information to be released.

You may leave a message on the following numbers:

Phone Number(s):_____
_____
_____

May we leave results of your tests on your voicemail? ☐ Yes ☐ No

May we leave appointment reminders on your voicemail? ☐ Yes ☐ No

You may speak with the following person about my financial and medical needs:

Name:_____
Relationship to Patient: _____
Phone Number:_____

You may speak with the following person about my financial and medical needs:

Name:_____
Relationship to Patient: _____
Phone Number:_____

Email Communication – Provide Email Address:

_____

☐ Financial ☐ Appointment Reminders
☐ Medical ☐ Breach Notification

☐For email communication: I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will be in effect until revoked by the patient.

_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)

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Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

I authorize the practice below to forward/release my health information:

- Primary Care Physician: _____ Practice Name:_____
- Hospital: _____ Other:_____

☐ **Entire record**
☐ Financial records
☐ Office visit notes
☐ Marketing* *Financial compensation is received for this communication
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):
☐ Other as listed

Please release my health information TO:

Mecklenburg Heart Specialists
2711 Randolph Rd. Suite 305
Charlotte, NC 28207
Phone: (704) 334-0600 Fax: (704) 334-0615

I authorize Mecklenburg Heart Specialists to forward/release my records to the following doctors:
(Please list any specialists, etc. that you would like to have your records forwarded to on the line below)

_____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)

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FINANCIAL POLICY

Thank you for choosing Mecklenburg Heart Specialists (MHS) as your healthcare provider. We are committed to providing the highest quality of medical care available in a cost effective manner. Our goal is to provide and maintain a good physician-patient relationship. Informing you of our office policy and your potential payment responsibilities allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Insurance

MHS participates with most major insurance companies. Your insurance identification card is required at the time of each visit. If you are a new patient and arrive without your card, you will be responsible for all charges until the billing office received complete, current and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty (30) days.

Verification of coverage/benefits will be attempted at or prior to your appointment. However, if we are unable to verify coverage, you will be asked to sign a waiver accepting full responsibility for your account if insurance fails to pay. Insurance verification is not a guarantee of coverage or payment. Insurance carriers have the final say regarding all coverage decisions. Patients will be responsible for any part of a service not paid by the insurance company in accordance with our contracts with them. This includes all deductibles, coinsurances and any services deemed as not eligible for payment due to policy guidelines and exclusions contained in their plans.

Co-payments/Deductibles/Co-Insurance

Please have your co-payment/co-insurance/deductible at the time of your appointment. These amounts are determined by your insurance company depending on your plan. All co-payments, plan deductibles that have not been met, and co-insurance amounts will be collected during the check in/out process.

Please remember, it is your responsibility to keep us informed of any changes in your health care coverage, address and telephone contact numbers.

Co-payments, co-insurance and deductibles are due on the day of services rendered.

If your insurance carrier determines a service to be “non-covered”, you will be responsible for the complete charge(s).

Non-Insured Patients

Non-insured patients will be required to pay for office visits and testing/procedures prior to being seen. There may be additional charge(s) depending upon the procedure(s) performed. Payment for additional services is due prior to leaving the office. All charges incurred at MHS are expected to be paid in full at the time of service, unless *prior* arrangements have been made with our business office.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

Please read both sides of this form

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FINANCIAL POLICY
continued

Appointment Cancellation / Missed Appointments

We request that you please give our office 24 hour notice in the event that you need to cancel or reschedule your appointment. If a patient misses an appointment and does not contact us at least 24 hours prior to the appointment, we consider this to be a missed appointment ("No Show, No Call") and the following fees will be assessed:

New Patient Visit	$150.00	Myoview (stress test)	$150.00
Echocardiogram/Ultrasound	$50.00	Follow Up Visit	$50.00

As a courtesy to our patients, we will attempt to contact you 2 (two) business days before your scheduled appointment. However, it is ultimately your responsibility to keep track of your appointments. If you do not receive your message or we have incorrect information, this policy will still apply. If you miss 3 appointments you may be dismissed from the practice.

Outstanding Account Balances

Any patient who has a personal balance on their account must pay that balance in full before your next appointment. If you are unable to pay in full, you must contact our business office. A late penalty of 1.5% per month (18% annually) will be added to any unpaid personal balances after 60 days. Balances that cannot be collected after our in-house collection procedures may be referred to an outside collection agency. Patients with unpaid delinquent balances must make satisfactory arrangement or settle the account before receiving future services.

Payment Options

For your convenience, we accept personal checks, credit/debit cards (MasterCard or Visa), or cash. Payments can be made via mail, in person, or by phone.

There will be a $25 charge for any returned checks.

MHS reserves the right to discharge or refuse services to patients for non-payment of services. If you have any questions regarding this policy, please let our staff know.

I have read and fully understand the financial policies of this office regarding payments and insurance.
I agree to pay for services and tests not covered by my insurance plan.
I understand that I am responsible for following my insurance plan's regulations, policies and procedures.

Patient Name: _____
please print

Responsible Party Name: _____ Relationship _____
If different from patient

Responsible Party Signature: _____ Date: _____

On completion, we will provide you with a copy for your records.
Please read both sides of this form

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Acknowledgement of Review of Notice of Privacy Practices

Patient Name: _____ DOB: _____

Address: _____

_____

I have reviewed the Notice of Privacy Practices for the above named practice and am aware a copy will be provided to me if requested.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of review of the Notice of Privacy Practices for the following reason:

- □ An emergency existed and signature was not possible at the time.
- □ The individual refused to sign.
- □ A copy was mailed with a request for signature by return mail.
- □ Unable to communicate with the patient for the following reason:

  _____

- □ Other: _____

  _____

Prepared by: _____

Signature:_____ Date: _____