NorthStarr Cardiothoracic Surgery

PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: ____/____/____ **Age**: _____
First M Last

Social Security #: _____- _____ - _____ **Gender:** ☐ M ☐ F **Referred By**: _____

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Physical Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Primary Phone Number: _____ ☐ OK to leave detailed message ☐ Leave call back number only

Alternate Phone Number: _____ ☐ OK to leave detailed message ☐ Leave call back number only

Email Address: _____

EMERGENCY CONTACT

Name: _____ **Relationship**: _____ **Phone**: _____

INSURANCE INFORMATION

Primary Insurance: _____
I.D. Number: _____ **Group:** _____
Subscriber Name (If different): _____
Subscriber Employer: _____
Subscriber D.O.B: _____
Relationship: _____

Secondary Insurance: _____
I.D. Number: _____ **Group:** _____
Subscriber Name (If different): _____
Subscriber Employer: _____
Subscriber D.O.B: _____
Relationship: _____

All Patients: 18 years and older must present with valid photo identification. Children under the age of 18 must have a parent or legal guardian present during their appointment. By signing below, I give my consent for examination, and the performance of any necessary tests and/or procedures. If patient is a minor: As the above patient's legal guardian, I give consent for examination and treatment, to include necessary tests and/or procedures.

I authorize release of any information necessary to process my insurance claims, and assign/request payment to be made directly to the provider(s). I understand that I may revoke this consent at any time in writing to this office. I further understand that I am responsible for payment for all services rendered to me, or any patient for which I am listed as the responsible billing party.

_____ _____ _____
Patient Signature or Legal Guardian If Guardian- Relationship Date

NorthStarr Cardiothoracic Surgery

REVIEW OF HEALTH

Patient Name: _____ **Date of Birth**: ____/____/____ **Age:** _____ **Male** ☒ **Female** ☐

Accompanied by: _____ **Relationship:** _____

Primary Care Physician: _____ **Cardiologist:** _____
Pulmonologist _____ **Oncologist:** _____

Chief Complaint: Please list (in order of importance) the present health concerns, symptoms or problems you are experiencing: _____
_____
_____
_____

Past Medical History: Please list all operations and other hospitalizations:

Date	Surgery or Hospitalization	Other Diagnoses		Since
_____		High Blood Pressure	☐	_____
_____		High Cholesterol	☐	_____
_____		Asthma/ Emphysema	☐	_____
_____		**Diabetes:**	☐	_____
_____		**Coumadin Management:**		_____

Other Illnesses: _____

List all MEDICATIONS AND DOSES (Include aspirin, birth control, vitamins, natural supplements & Rx)

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

Allergies: _____

Social History: **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Other **Jehovah's Witness Faith?** ☐

Number of Children: _____ **# of Grand Children:** _____ **# of Great Grand Children:** _____

Employer: _____ **Occupation**: _____

Have you ever smoked in the past? No ☐ Yes ☐ **Tobacco:** _____ pack/day **Starting Age:** _____ **Age Stopped**: ___

Alcohol Frequency: _____/week **Caffeine:** _____ cups/day **Recreational Drugs**: _____

Exercise Habits: _____

Family History: Father: Living/ Deceased: Age_____ Illnesses/Cause of Death_____
Mother: Living/ Deceased: Age_____ Illnesses/Cause of Death_____
Siblings: # of Brothers____ Ages_____ Illnesses/Cause of Death_____
Siblings: # of Sisters_____ Ages_____ Illnesses/Cause of Death_____

Review of Systems: **Difficulty with Anesthesia?** No ☐ Yes ☐ **What Occurred?** _____

Symptoms that have occurred once a week or more **in the past 12 months.** Please select **No** or **Yes**

- Headaches ☐
- Dentures: Upper/Lower ☐
- Partials: Upper/Lower ☐
- Tire Easily ☐
- Weight Change _____ ☐
- lbs Sensitivity to Cold ☐
- Sensitivity to Hot ☐
- Persistent Fever ☐
- Night sweats ☐
- Hot Flashes ☐
- Excessive Thirst ☐
- Skin Rash ☐
- Change in Nails ☐
- Easy Bleeding ☐
- Easy Bruising ☐
- Blurred Vision ☐
- Double Vision ☐
- Infected Eyes ☐
- Eye Pain ☐
- Ringing Ear ☐
- Discharge from Ears ☐
- Hearing Loss ☐
- Hearing Aids ☐
- Frequent Nose Bleeds ☐
- Sinus Problems ☐
- Loss of Smell ☐

- Persistent Hoarseness ☐
- Sore Throat ☐
- Chronic Cough ☐
- Shortness of Breath ☐
- Blood in Sputum ☐
- Wheezing ☐
- Chest Pain ☐
- Swelling of Hands & Feet ☐
- Heart Palpitations ☐
- Difficulty Swallowing ☐
- Heart burn ☐
- Abdominal Cramping ☐
- Nausea ☐
- Vomiting ☐
- Cough/Vomited Blood ☐
- Chronic Constipation ☐
- Chronic Diarrhea ☐
- Rectal Bleeding ☐
- Black Tarry Stool ☐
- Dark Urine ☐
- Frequent Urination ☐

Times per Day:

- Difficult Urination ☐
- Painful Urination ☐
- Leakage of Urine ☐
- Blood in Urine ☐

- Arthritis ☐
- Swollen Joints ☐
- Leg Cramps ☐
- Varicose Veins ☐
- Sleeplessness ☐
- Anxiety ☐
- Depression ☐
- Memory Loss ☐
- Dizziness ☐
- Fainting ☐
- STD: ☐

Men:

- Penial Discharge ☐
- Pain in Testes ☐
- Impotence ☐
- Enlarged Prostate ☐

Women:

- Breast Pain ☐
- Breast Lump ☐
- Nipple Discharge ☐
- Heavy Bleeding ☐
- Pelvic Pain ☐

Last Menstrual Cycle: _____

Official Use Only

Height: _____ Weight: _____

BP: _____ Pulse: _____

BMI: _____ Temp: _____ O2: _____

Signature: _____ Date: _____

PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT

I, the undersigned, do hereby consent and agree that I have received a copy of the Patient's Right to Privacy Policy or have declined at this time.

Print Patient Name

If guardian- Relationship

Patient Signature or Legal Guardian Date

NorthStarr Cardiothoracic Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NCS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-907-917-2200

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-907-917-2200.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

BY NorthStarr Cardiothoracic Surgery

PATIENT NAME: _____

You MUST complete all of the information in this form for your authorization to be valid.

MAIL OR Fax this completed form to NorthStarr Cardiothoracic Surgery

3841 Piper Street, Suite T382, Anchorage, AK 99508, Fax: 907-865-7944 Office phone: 907-917-2200

I authorize and instruct NorthStarr Cardiothoracic Surgery to use or disclosure of my health Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment enrollment of eligibility for benefits on whether or not I give the authorization listed in this form.

(1) NorthStarr Cardiothoracic Surgery can release PHI to: NorthStarr Cardiothoracic Surgery, its agents or subcontractors (Business Associates) is authorized to release the PHI described below to the following person, class of persons, or organization:

Please circle all that apply and list their name:

My spouse Parents Legal Representative Insurance Company Care Giver Children Other

(Print Name / Relationship)

_____

_____

(2) The information that may be used or released is:

Medical information held by NorthStarr Cardiothoracic Surgery from the following doctor, clinic, or hospital:

_____

_____

Information held by NorthStarr Cardiothoracic Surgery concerning my eligibility, claims decisions and payments.
Other, please specify below:

_____

_____

(3) **Right to revoke**: I understand that I have the right to revoke this authorization at any time by notifying NorthStarr Cardiothoracic Surgery contact person in writing to the address listed at the top of this form. I understand that the revocation is only effective after it is received and logged by NorthStarr Cardiothoracic Surgery, I understand that any use of disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is release, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold NorthStarr Cardiothoracic Surgery and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that Starr-Wood Cardiac Group will give me a copy of this authorization.

(6) **THIS AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECITY ANOTHER DATE OR TERMINATION EVENT BELOW.**

Other: _____

Your Signature: _____ **Date:** _____

Print Your Name: _____ **Social Security Number:** _____

FINANCIAL POLICY

We are dedicated to providing the best possible care and customer service for you. We want you to understand our financial policy so that we can work collaboratively to achieve reimbursement for services we rendered for you.

- Payment on services billed to an insurance carrier will be due 60 days from the date the claim was submitted to the insurance carrier listed on the billing information provided by the Hospital.
- Patients without insurance will be billed directly and are required to pay the balance on their account.
- We do not charge interest on accounts but we expect accounts to be paid within a year of the initial service provided. For your convenience, we accept Visa and MasterCard. We recognize that accounts with exceptionally large balances may require an extended payment period. Please contact our billing office for further details and to set up your payment plan. Note that once we agree to a payment plan, you have committed to make monthly payments. *We reserve the right to send your account to collections without notice if you miss a payment without communicating with our office.*
- Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim. If you have more than one insurance plan, be sure we know who they are; we will file secondary and tertiary insurance claims for you if notified promptly. If your insurance company does not pay the claim by 90 days of the submission date, we will look to you for payment. If we receive a payment from your insurer resolving your account creating an overpayment, we will refund you any amount you have paid us.
- We expect that if you have a co-pay or deductible that you will make payment on that amount upon receipt of the billing statement.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," or over their "allowable" amount, you will be responsible for payment of the balance remaining.
- If you are unable to meet your financial obligation, you may make financial arrangements with our office or apply for charity. Please do so before your account is in arrears. If you are granted charity and neglect to adhere to your payment plan, your account will be sent to collections with the original (pre-charity) amount due.
- To avoid collection activity, payment in full is due upon receipt of the billing statement.
- **NorthStarr accepts all insurance plans, including private insurance plans however, we are only contracted with Medicaid, Medicare, VA and Tricare.**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Please **PRINT** Patient Name: _____

Sign: _____