St. Clair Health

St. Clair Medical Group

Today's Date: _____

New Patient Registration Form

Patient Demographic Information

Full Legal Name: _____
Last First Middle

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Other _____
MM / DD / YYYY *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated **Please Address As:** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Address:

_____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Email Address: _____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: _____ **Occupation:** _____

Emergency Contact: _____
Name Relation Phone Number

If Minor, Parent / Guardian: _____
Name Relation Phone Number

Primary Insurance	**Secondary Insurance (If applicable)**
Policy Holder Name _____	Policy Holder Name _____
ID# _____ Group # _____	ID# _____ Group # _____
Address _____	Address _____
Phone # _____	Phone # _____
DOB _____ SS# [optional]_____	DOB _____ SS# [optional]_____
Relationship to Patient _____	Relationship to Patient _____

Workers Compensation/Auto (if applicable)

Name of Insurance Company _____ Phone # _____ Fax # _____
Claim # _____ Date of Injury _____ SS# [optional]_____
Billing Address _____
Adjuster Name _____ Phone # _____
Employer Contact _____ Phone # _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other health plan benefits to the St. Clair Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Group for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Patient or if a minor, Responsible Party Date

St. Clair Health

St. Clair Medical Group

St. Clair Medical **Group** Policies & HIPAA

*Welcome to **St Clair Medical Group** and thank you for choosing us as your healthcare provider. We would like to take this opportunity to advise you of our practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.*

NOTICE OF PRIVACY PRACTICES

We value our patients' rights to privacy in regard to their health information. Please take a moment to review our Notice of Privacy, which provides a complete description of permitted uses and disclosures of healthcare information.

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I wish to allow disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

NAME	RELATIONSHIP	DISCLOSURE	IF LIMITED, PROVIDE DETAILS
		☐ FULL ☐ LIMITED	
		☐ FULL ☐ LIMITED	
		☐ FULL ☐ LIMITED	
		☐ FULL ☐ LIMITED	

In the event that we need to contact you, are we permitted to leave a message on your answering machine? ☐ **Yes** ☐ **No**

ST. CLAIR MEDICAL GROUP POLICIES

- You are responsible for notifying us of any changes to your address, personal information, or insurance information.
- **St Clair Medical Group** is pleased to process your insurance claim for reimbursement. However, please remember that:
  - You must present your insurance card and photo ID at each visit.
  - Your insurance is a contract between you, your employer, and the insurance company. **St Clair Medical Group** is not a party to your health insurance contract.
  - Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
- All copayments are to be paid in full at the time of service.
- If you do not have health insurance coverage or do not bring proof of health insurance coverage to each visit, payment in full will be due at the time of your visit.
- We accept payments in the form of cash, personal check, and most major credit cards. However, we **do not accept Care Credit.** If you are in need of financial assistance, please review St. Clair Medical Group policy on https://www.stclair.org/billing-insurance/financial-assistance/
- **St Clair Medical Group** and/or agencies working on St Clair Medical Group's behalf may need to contact patient or guarantor via land phone line or cell phone regarding balance due for services.
- Out of consideration to our other patients, if you arrive more than 15 minutes late to your appointment, there may be a delay in your visit, or you may be asked to reschedule your appointment.
- Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least **24 hours in advance** to reschedule.
- **St Clair Medical Group** requests previous medical records so that we may have the best understanding of your medical history.

PATIENT ACKNOWLEDGEMENT

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the Notice of Privacy Practices.

_____ _____ _____

Patient Name (PRINTED) **Signature of Patient or Responsible Party, if a Minor** **Date**

FOR OFFICE USE ONLY
A good faith effort was used to obtain written acknowledgement of the Notice of Privacy Practices on:
Office Staff Name (PRINTED):_____ Office Staff Signature _____ Date:_____

St. Clair Health

St. Clair Medical Group-Cardiology

Name (Last, First, M.I.)	
☐ **M** ☐ **F**	**DOB:** / /
Primary Care Physician:	
Local Pharmacy:	
Local Pharmacy Phone:	( ) -
Mail Order Pharmacy:	

Please explain reason for visit below.

Past Medical History

Check if you have, or have had, any symptoms in the following areas to a significant degree.

☐ Chest Pain	☐ Mitral Valve Prolapse	☐ Gastrointestinal Disorder
☐ Fainted	☐ Atrial Fibrillation	☐ Thyroid Disease
☐ Palpitations	☐ Peripheral Vascular Disease	☐ Kidney Disease
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ Liver Disease
☐ Murmur	☐ Diabetes- Insulin	☐ Cancer
☐ Valve Disease	☐ Diabetes- Non Insulin	☐ **Other:**
☐ Heart Failure	☐ High Cholesterol	☐
☐ High Blood Pressure	☐ Lung Disease	☐
☐ Heart Disease	☐ Pneumonia	☐
☐ Heart Attack	☐ Asthma	☐
☐ Pacemaker ☐ St. Jude ☐ Biotronik ☐ Medtronic ☐ Boston Scientific	☐ Defibrillator ☐ St. Jude ☐ Biotronik ☐ Medtronic ☐ Boston Scientific	☐ Sleep Apnea ☐ Oxygen ☐ C-Pap ☐ Bi-Pap

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St. Clair Health

St. Clair Medical Group-Cardiology

Surgical History

Please list:	
◘	**Date:**
◘	**Date:**
◘	**Date:**
◘	**Date:**
◘	**Date:**
◘	**Date:**

Family History

Check if anyone in your family has a history of the following:

Colon Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Ovarian Cancer	☐ Mother	☐ Grandparent		☐ Sibling
Skin Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Breast Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Prostate Cancer	☐ Father	☐ Grandparent		☐ Sibling
Lung Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Diabetes	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Renal Disease	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Heart Disease	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Stroke	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Coronary Artery Disease	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
High Blood Pressure	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
High Cholesterol	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
Sudden Cardiac Death	☐ Father	☐ Mother	☐ Children	☐ Sibling

Social History

Occupation:		**Where employed:**	
Job Duration (yrs):		**Education Level:**	
Hobbies, interests:		**Pets:**	
With whom do you live?		**Where do you live?**	☐ House ☐ Apartment ☐ Assisted Living ☐ Skilled Nursing
Marital Status:		**Years Married:**	

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Spouse's Name:		**Number of Children:**	

Risk Factors

Tobacco Use: ☐ Current every day smoker ☐ Current occasional smoker ☐ Former Smoker ☐ Never Smoker

☐ Cigarettes _____ pks/day
☐ Cigars _____ #/day
☐ Smokeless / Chewing _____ #/day

Year Started: _____
Year Quit: _____

Are you exposed to second hand smoke? ☐ Yes ☐ No

Any other drug use? ☐ Yes ☐ No **If yes please explain:**

Do you use alcohol? ☐ Yes ☐ No

How many drinks do you have per day?

Type:

Do you drink caffeine? ☐ Yes ☐ No _____ (drinks per day)

Do you exercise? ☐ Yes ☐ No _____(times/week)
Type of exercise?

Medications

List your prescribed medications and over-the-counter medications, such as vitamins and inhalers. If there is not enough room, please bring a separate medication list.

Name of Drug	Strength	Frequency Taken

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St. Clair Health

St. Clair Medical Group-Cardiology

Allergies to Medications

Name of Medication	Reaction You had

Height:	Weight:

Cardiac Studies

Check if you have, or have had any of the following testing.

☐ Echocardiogram	☐ Heart Catheterization	☐ Carotid Doppler
☐ Transesophageal Echo (TEE)	☐ Balloon Angioplasty / Stent	☐ EKG
☐ Stress Test	☐ Open Heart Surgery	☐ Holter Monitor
☐ Event Monitor	☐ EP Study	☐ Implantable Loop Recorder
☐ Cardiac Ablation	☐ Vascular Angioplasty / Stent	☐ Cardioversion
☐ **Other:**	☐	☐

St. Clair Health
St. Clair Medical Group

Today's Date: _____

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ _____ _____ **Date of Birth:** _____
(LAST) (FIRST) (M.I.)

Address:

_____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Use and Disclosure of Protected Health Information

St. Clair Medical Group Cardiology is authorized to (circle one): **SEND** *OR* **RECEIVE**

Practice Address: 363 Vanadium Road, Suite 300, Pittsburgh, PA 15243
Phone Number: (412) 429-8840
Fax Number: 412-429-8067

Practice Address: 2000 Oxford Drive, Suite 305, Bethel Park, PA 15102
Phone Number: (412) 942-7900
Fax Number: 412-942-7918

_____ is authorized to (circle one): **SEND** *OR* **RECEIVE**
(PERSON(S) / ORGANIZATION(S))

Practice Address: _____
(STREET) (SUITE #) (CITY) (STATE) (ZIP CODE)

Phone Number: _____ *Fax Number:* _____

My health information will be used for the following purpose(s): _____

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient ❑ Outpatient ❑ TCC ❑ IRU
❑ Discharge Summary ❑ Imaging Reports ❑ PT/OT/Speech/Audiology

Treatment Dates: _____

❑ History & Physical ❑ Laboratory Reports ❑ Operative Reports ❑ Emergency Department Record
❑ Consultations ❑ Transfer Abstract ❑ Transfer Abstract ❑ Pathology Reports
❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts
❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services
❑ Specific Exclusions: _____

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ will or ❑ will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires **[insert date or event]** if less than ninety days:_____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to one of the following addresses: **St. Clair Medical Group Cardiology**

1) **2000 Oxford Drive, Suite 305, Bethel Park, PA 15102**
2) **363 Vanadium Road, Suite 300, Pittsburgh, PA 15243**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: _____ **Time:** _____ AM / PM

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

_____ _____/_____/_____
Witness Date

_____ _____/_____/_____
Witness Date