TANNER PHYSICIAN SERVICES PATIENT CREDIT POLICY

PATIENT INFORMATION & NOTIFICATION

We have established a Credit Policy and/or a Billing & Collection Policy to utilize in order to insure uniform and consistent methods of handling our patient's accounts. We value our relationship with our patients and want to insure that you are aware of our method(s) for handling the financial aspect of the services rendered to you.

Below stated is our policy:

POLICY: The Tanner Medical Group Business Services Department staff is committed to 100% Customer Service. Patients are responsible for all charges resulting from treatment provided by Tanner Physicians. We will bill most insurance carriers directly as a courtesy to our patients. In cases where we accept "Assignment of Insurance" benefits, the deductible and co-insurance payments are expected at time of service. Self-pay/no insurance payment is due at time of service unless prior arrangements have been made with the Medical Group's Business Service Department.

PATIENT RESPONSIBILTY:

We request that you provide to our office current complete insurance information in order to bill your insurance carrier.

We request that you pay amounts due from patient at the time of service.

We request that you provide to our office current complete demographic information in order to correspond with you regarding your services rendered and/or any amounts due.

ADDITIONAL INFORMATION:

Failure to pay patient balance due, which includes patient co-payment amounts, may result in dismissal from Tanner Physician Group practices.

Date: _____ Patient/Guarantor: _____

PATIENT HISTORY FORM

Name: _____ Date: _____ Dr.: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Race: _____

PATIENT:
Why are you here to see a cardiologist?
_____
_____
_____

Check any of the below heart problems or symptoms that apply:
_____ Heart Attack
_____ Angina
_____ High Blood Pressure
_____ Heart Murmur
_____ Rheumatic Fever
_____ Abnormal Rhythm (arrhythmia)
_____ Palpitations, irregular heartbeats
_____ Fainting
_____ Enlarged Heart
_____ Chest Pains or Pressure
_____ Shortness of Breath
_____ Dizziness
_____ Swollen Legs
_____ Heart Failure
_____ Blue Lips or Fingernails
_____ Leg Cramps When Walking

Have you ever had?
_____ A Stress Test
_____ An Echocardiogram
_____ Cardiac Catheterization/Heart Catheterization
_____ Coronary Angioplasty (balloon)
_____ Coronary Bypass Surgery
_____ Valve Surgery
_____ An Electrophysiology Study or Procedure
_____ A Pacemaker or Defibrillator

Please check if you have:
_____ High Blood Pressure
_____ High Cholesterol
_____ Ever Smoked
_____ Diabetes

Do you exercise (including walking)?
_____
Has a close family member had a heart attack, angina, or bypass surgery? _____
Who? _____
If you are a woman, have you passed menopause? _____
At what age? _____
Do you take estrogen replacement? _____
Please tell us about your heart:
_____
_____

Have you ever taken blood thinners? _____

HPI (Circle): Brief Extended
Elements: Location, quality, severity duration, timing, context, modifying factors, associated signs and symptoms

Brief 1-2 elements; Extended >4 elements

PATIENT HISTORY FORM

Name: _____ Date: _____ Dr.: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Race: _____

List any illness you are currently being treated for or have been treated for in the past.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any operations and/or injuries (Include dates)

1. _____
2. _____
3. _____
4. _____
5. _____

Marital Status: Single Married Widowed Divorced

With whom do you live? _____

What is their relationship to you? _____

What is your occupation? _____

Leisure Activities _____

_____

Education Level _____

Health Habits

Do you smoke? _____

How many packs per day? _____

For how many years? _____

If non-smoker, have you:

Never smoked _____

Smoked and stopped _____

Do you drink alcoholic beverages at present time? _____

If yes, indicate how many drinks per week including mixed drinks, beer and wine: 1-5 6-12 13-25 26 or more

Check if any close family members (parents, brothers or sisters, and children) have:

_____ Heart problems

_____ High Blood Pressure

_____ Diabetes

_____ Cancer

Are there any other health problems in your family?

_____

_____

Is your mother living or deceased? _____

If deceased, what was the cause of death? _____

_____

At what age did she pass? _____

Is your father living or deceased? _____

If deceased, what was the cause of death? _____

_____

At what age did he pass? _____

Do you have any siblings that are deceased? _____

If so, what was the cause of death and at what age?

_____

List any medications you are allergic to and what kind of reaction you have:

1. _____
2. _____
3. _____
4. _____
5. _____

PATIENT HISTORY FORM

Name: _____ Date: _____ Dr.: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Race: _____

Please circle any symptoms you have, so we can find out more about it:

	ROS
lack of energy; trouble sleeping; loss of appetite; weight changes; fevers	Constitutional
Eye problems, such as double or blurred vision; glaucoma	HEENT
Hearing problems; buzzing or ringing in ears	
Allergies; hay fever	
Sinus problems	
Breathing problems; wheezing, coughing; coughing blood	Respiratory
Asthma; tuberculosis	
Stomach problems; indigestion; change in bowel habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems; frequency; infections; stones; bladder	Urinary
Men: Prostate problems; nighttime urination	
Women: Abnormal menstrual periods. Could you be pregnant?	
Breast lumps; Recent mammogram; pap smear and/or pelvic exam	
Joint pains; swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skim problems	Dermatological
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorders; diabetes; excessive thirst, hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological