



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 RESPONSIBILITY:

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:

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

Have you ever taken blood thinners? _____

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. _____

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

- 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?

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 skin 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