PROVIDENCE
Spokane Heart Institute

Spokane Cardiology

Tel: 509-455-8820 or 1-800-755-5857 **Fax:** 509-838-4978

Welcome to Providence Spokane Cardiology

On behalf of the entire staff, we would like to welcome you. We look forward to providing an office environment and provider relationship that meets you and/or your family's cardiac needs.

Providence Spokane Cardiology has 37 providers and continues to grow. To help serve our patients and communities, we have clinics in five different locations. We pride ourselves in knowing your care will be monitored by our team of Cardiologists and Advanced Practice Providers (APPs). Our APPs and their advanced training in Cardiovascular Disease has allowed us to handle our patients care with a team approach. Our APPs collaborate with our Cardiologists to provide the best care to our patients in a variety of clinical settings. Your consultation may be scheduled with one of our APPs, this not only extends your support by the APP but it also allows more patient's access to a Cardiology consult. Routine visits in general rotate between the APP and your assigned Cardiologist. Because our APPs work alongside a Cardiologist, they are able and willing to seek assistance if your problem requires more in-depth care. Our goal is to provide you with outstanding service.

Your trust in our knowledge and expertise is very important to us.

The day of your appointment

- Check-in is **15 minutes** prior to your scheduled appointment time
- Copay or deposit amount is due at the time of service
- Bring your insurance card(s) and photo ID
- Bring all non-narcotic medications in their **original containers** and a list of your narcotic medications
  - Please **do not** bring in any of your narcotic medications with you

If you need to cancel or reschedule your appointment, please give us **24 hours**' notice

- Call 509-455-8820 or 1-800-755-5857 Monday-Friday 730am-500pm
  - Option 2 for Scheduling

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge and bring with you on the day of your appointment.

- Office Policies and Expectations
- Your Scheduled Appointment Date, Time and Location
- MyChart Activation
- Narcotic Medication List
- Patient Intake

We look forward to meeting you.

Sincerely,

The Spokane Cardiology Group

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Office Policies and Expectations

Please review and initial indicating you have read and understand our office policies and expectations.

Patient Name: ______________________ ______________________ D.O.B: _____________ Date: ___________
(First) (Last)

_________ *initials* **Financial Policy**

We recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship.

- Make sure you have a good understanding of what is and is not covered by your insurance plan
  - You can contact our billing office **1-866-747-2455** with questions regarding fees or financial responsibilities
- Co-pays are due at the time of service
  - We accept cash, checks, VISA, MasterCard, Discover and American Express
- Self-pay patients are required to pay a deposit at the time of service
  - **$75.00** New Patient and **$50.00** Established Patient
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage
  - If necessary please make sure your referring provider has obtained any necessary prior authorization or referral required by your insurance company
- If we are contracted with your insurance we will bill your insurance company first, then bill you for any amount determined to be your responsibility
- Any procedures, lab work, diagnostics, etc that you have completed outside of this office or that is sent for interpretation, is not included in the charge for your office visit(s). You will receive a separate bill for those charges directly from the facility providing the service

_________ *initials* **No-Show Policy**

As a courtesy to all of our patients, you will receive a reminder call two business day prior to your scheduled appointment with the date and time. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide us **24 hour notice** if you are unable to keep your scheduled appointment.

To improve care for our patient, we will track "No-Show" activity. All **new patients** are allowed to miss one scheduled appointment without penalty. Once a second appointment is missed, the patient will be discharged from the practice and their referring provider will be notified. All **established patients** will be allowed to miss two scheduled appointments without penalty. Once the third appointment is missed, the patient will be at risk of being discharged from the practice. To prevent this from happening, patients will receive a letter when they no-show their scheduled appointment.

A no-show is defined as below:

- An appointment which is missed by the patient without any advance notice

_________ *initials* **RX Refill Policy**

Please contact your pharmacy directly for all prescription refills. We require **48 hours' notice** for all prescription refill requests. If you have requested a refill and it's been longer than 48 hours please feel free to call us.

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Scheduled Appointment(s)
Thank you for taking the time to schedule with us, below you will find your scheduled appointment(s) date, time and location.

- **1st Scheduled Appointment**

For a: ________________________________ With: _______________________________________

Date: ______________________ Arrival Time: ______________ Appointment Time: ______________

□ **Spokane Heart Institute**
122 W 7th Ave Ste.______
Spokane WA 99204

□ **Spokane Heart Institute - Diagnostics**
122 W 7th Ave Ste. 230
Spokane WA 99204

□ **Holy Family Medical Building**
212 E Central Ste. 240 Ste. B3200
Spokane WA 99208

□ **Providence Medical Park**
16528 E Desmet CT
Spokane Valley WA 99216

□ **Valley Medical Center**
2315 8th Street
Lewiston ID 83501

- **2nd Scheduled Appointment**

For a: ________________________________ With: _______________________________________

Date: ______________________ Arrival Time: ______________ Appointment Time: ______________

□ **Spokane Heart Institute**
122 W 7th Ave Ste.______
Spokane WA 99204

□ **Spokane Heart Institute - Diagnostics**
122 W 7th Ave Ste. 230
Spokane WA 99204

□ **Holy Family Medical Building**
212 E Central Ste. 240 Ste. B3200
Spokane WA 99208

□ **Providence Medical Park**
16528 E Desmet CT
Spokane Valley WA 99216

□ **Valley Medical Center**
2315 8th Street
Lewiston ID 83501

If you need to cancel or reschedule your appointment, please give us **24 hours**' notice

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MyChart

Our secure online medical records system, gives you more flexibility and direct access to your health information. It is accessible on the internet via your computer, and as an app for your smartphone. The more you know about your healthcare, the greater our partnership can be.

MyChart allows you to:

- View your healthcare summary, current health conditions and health history
- Securely communicate with your provider's office online
- View test results
- View current medication, immunizations and allergies
- Receive paperless bills and pay your bill online
- View upcoming and past appointments

To assist you with activating your MyChart account during your office visit please complete the below. This form is for your records and will not be kept as a part of your medical chart.

Patient Name: ______________________________ ______________________________ D.O.B: _____________
(First) (Last)

Email: ____

Answer one security question

- ☐ Where were you born _________________________________
- ☐ Name of first pet _____________________________________
- ☐ Mother's maiden name ________________________________
- ☐ High school you attended ______________________________

Create Username: ______________________________ (letters, numbers)

Create Password: ______________________________ (case sensitive, letters, numbers)

Once you are registered you can log into your MyChart account at www.providence.org/mychart

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Narcotic Medication and Allergy List

Please complete to the best of your knowledge.

Patient Name: ______________________________ ______________________________ D.O.B: _____________

(First) (Last)

Please list all narcotic medications (Codeine, Hydrocodone, Oxycodone, etc.). Only bring non-narcotic prescriptions, over the counter medications and herbal or supplements to your appointment in their original containers.

Narcotic Medication Name	Dose	When is it taken	Route

Please list any known medication allergies.

Medication Allergies	Reaction

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New Patient Intake Form

Please bring all non-narcotic prescriptions, over the counter medications and herbal or supplements to your appointment in their original containers.

Patient Name: ______________________________ ______________________________ D.O.B: _____________
(First) (Last)

Referring Physician: _________________________________ Primary Physician: _________________________________

<u>Past Medical History</u>

Cardiac:____

Diabetes: Type 1 or 2

COPD: Yes or No

Renal Failure: Yes or No - if yes Stage: 1, 2, 3, or 4

Sarcoidosis: Yes or No

Stroke or TIA: Yes or No

Thyroid Disease: Yes or No

Cancer/s: ____

Bleeding Disorders: Yes or No

yes: ____

Auto Immune Disease: Lupus or Rheumatoid arthritis

<u>Past Surgical History & Dates</u>

Cardiac: ____

Vascular: ____

Mastectomy/Lumpectomy: ____

Transplants: ____

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Family Medical History

Please check if any family members had any of the following ***prior to age 60:***

Father ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Mother ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Brother/Sister ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Brother/Sister ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Brother/Sister ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Brother/Sister ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Son/Daughter ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Son/Daughter ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Son/Daughter ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Maternal Grandfather ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Maternal Grandmother ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Paternal Grandfather ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

Paternal Grandmother ☐ Coronary artery disease ☐ Heart attack ☐ Stroke/TIA ☐ Sudden cardiac death
Cause of death if cardiac related ______

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Socioeconomic

Occupation: ____

Retired/previous occupation**:** ____

Marital Status:

Married   Divorced   Single   Widowed   Legally Separated   Significant Other

Significant Others Name: ____

Substance Use

Cigarette Smoking status:

Current   Former

Start Date: ____________   Quit date:________________

Packs/Day: ____________   Packs per day:_____________ Years smoked:______________

Smokeless Tobacco: Snuff or Chew

Current   Former

Quit Date: ________________

Alcohol use: Yes or No

Drinks per week: __________ Wine/Beer/Shots of liquor/or standard drinks.

Recreational/Street drug use: Yes   No   Former

Types: ___________________________   Quit date: ___________________

Use/Week: _______________________   Use/week: ___________________

Caffeine Consumption:

Caffeine use: Yes or No

What type: ___________________

Quantity per day/week: ___________________________

Exercise/Activity:

- ☐ Sedentary- Activities of daily living (ex. walking to mailbox)
- ☐ Mild- 3X a week for 20 minutes (aerobics)
- ☐ Moderate- 5X a week for 30 minutes (aerobics)
- ☐ Very- 6X a week for 45 minutes (vigorous aerobics/strength)
- ☐ Physical Therapy
- ☐ Cardiac Rehab