# SOUTH CHARLESTON CARDIOLOGY ASSOCIATES
## PATIENT QUESTIONNAIRE

**Patient Name:**________________________ **DOB:**______________ **Date:**______________

## SINCE YOUR LAST OFFICE VISIT, HAVE YOU HAD ANY OF THE FOLLOWING:

| PROCEDURE | APPROXIMATE DATE OF SERVICE | PLACE OF SERVICE |
| --- | --- | --- |
| ☐ Blood Work/Cholesterol | ____________ | ____________ |
| ☐ Stress Test | ____________ | ____________ |
| ☐ Echocardiogram | ____________ | ____________ |
| ☐ Heart Cath/Stent or Heart Surgery | ____________ | ____________ |
| ☐ Any Hospitalization | ____________ | ____________ |
| ☐ Carotid Ultrasound | ____________ | ____________ |

South Charleston Cardiology Associates, PLLC
Kishore K Challa, MD, FACC
M. Babar Yousaf, MD, FACC
Joseph DeVono, III, DO, FACC
Medical Office Pavillion
4607 MacCorkle Ave, SW; Suite 300
South Charleston , WV 25309

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please print. All information will be confidential.

## Patient Information Sheet

Date: ____________________

First Name: ____________________ Middle: ____________________ Last: ____________________

Address: ________________________________________

City: ____________________ State: ____________________ Zip Code: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

circle primary contact number E-Mail ____________________

Date of Birth: ____________________ SSN: ____________________ Male ☐ Female ☐

Employer: ____________________ If Retired From Where: ____________________

Marital Status: ____________________ Language: ____________________ Race: ____________________

Emergency Contact Name and Relationship: ____________________ Emergency Contact Number: ____________________

Referring MD: ____________________ Phone: ____________________

Family Physician: ____________________ Phone: ____________________

### Insurance Information

**(a copy of card must be provided)**

**Primary Insurance:** ____________________ Phone Number: ____________________

Name of Insured: ____________________ Relationship to Patient: ____________________

** Insured's Date Of Birth: ____________________

ID Number: ____________________ Group Number: ____________________

**Secondary Insurance:** ____________________ Phone Number: ____________________

Name of Insured: ____________________ Relationship to Patient: ____________________

** Insured's Date Of Birth: ____________________

ID Number: ____________________ Group Number: ____________________

**Tertiary Insurance:** ____________________ Phone Number: ____________________

Name of Insured: ____________________ Relationship to Patient: ____________________

** Insured's Date Of Birth: ____________________

ID Number: ____________________ Group Number: ____________________

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Charleston Cardiology Associates, PLLC to release any information required to process my claims directly to my insurance.

**Patient or Guardian Signature:** ____________________ Date: ____________________

**** Required**

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# Communication and Consent

**I give my permission to be contacted in the following manner (check all that apply):**

**Home Telephone:**

- [ ] Ok to leave a message with information
- [ ] Leave a message with only call back number
- [ ] Ok to leave message with following family members:

______________________________

______________________________

______________________________

**Work Telephone:**

- [ ] Ok to leave a message with information
- [ ] Leave a message with only call back number

**Written Communication**

- [ ] Ok to mail to home address
- [ ] Ok to fax this number

In accordance to HIPPA rules and regulation, I, ______________________________
authorize ______________________________ to speak with the staff at South Charleston Cardiology Associates, PLLC, concerning my care and protected health information (test results, labs, appointments, and general care).

I also understand that I retain the right to revoke this authorization. In order for the revocation of this authorization to be effective, South Charleston Cardiology Associates, PLLC, must receive the revocation in writing. The revocation must include:

* My Name
* The Effective Date of This Authorization
* My desire to revoke authorization, and
* The date of the revocation and my signature.

According to HIPPA regulations, I have received a Notice Of Privacy Practices, which tells how my health information may be used and shared. I understand that South Charleston Cardiology Associates reserves the right to revise the notice at anytime and that I will be provided a current copy at my request.

I fully understand and accept the terms of this authorization.

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Signature of Patient's Legal Representative or Guardian Date

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**Medical Office Pavilion**
**4607 MacCorkle Avenue, SW; Suite 300**
**South Charleston, WV 25309**

## Payment Policy

Thank you for choosing us as your medical care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate with most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you have any questions regarding your co pays or deductibles please contact your insurance.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If

your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due and no payment has been made, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account for collection action and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_______________________________________ ____________________

**Signature of patient or responsible party/Date**