Mountain Heart™
Advanced Technologies. Hands On Care.

WELCOME TO MOUNTAIN HEART

Dear New Patient,

Welcome to Mountain Heart Cardiovascular Care Center and Accredited Sleep Facility. It is our pleasure to serve you. Our goal is to provide you with exceptional customer service in a safe healthcare environment that emphasizes the importance of being proactive about your health. We strive to meet all of your heart care needs and provide you with the highest quality care at the lowest price point possible.

Please take a moment to complete the attached patient information and at your convenience, review our complete office policies and learn about additional services we offer online at www.mountainheartcares.com. If there is anything we can do to improve your experience at any point, please do not hesitate to let us know.

In our efforts to maintain cost efficient care and stay on-time during clinic, we need your help. The following policies help us to ensure an on-time visit, and avoid any financial surprises:

1) **CANCELLATION POLICY:** All patients are required to provide 48 hour cancellation notice. This policy allows us to fill any vacant appointments with a patient that needs to be seen urgently. Multiple cancellations without notice may be cause for termination from the practice.
2) **ZERO TOLERANCE NO SHOW POLICY:** Mountain Heart does not permit missed appointments without notification to the practice. No show appointments cause a burden on the practice and limit our provider's ability to see urgent patients. After three no-show appointments within a 12 month period, patient accounts will be reviewed and may result in dismissal from the practice.
3) **CO-PAYS/DEDUCTIBLES:** For the benefit of our patients we accept all insurances. We recomend that you check with your insurance company to verify that our providers are on the contracted provider list. As part of our contract with insurance companies we are legally required to collect co-pays and deductibles from you at the time of service. We ask that you be prepared to pay your co-pay and deductible at the time of the visit. We will accept cash, check, money order or credit card.

Please arrive 15 minutes before your appointment to allow time for registration. If you are late for your appointment we may need to reschedule.

We appreciate your help in maintaining our low costs and look forward to participating in your healthcare needs. Again, welcome to Mountain Heart.

Sincerely,

Your Mountain Heart Care Team
Dr. Kent Winkler, MD, FACC, FSCAI
Medical Director

2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

PATIENT INFORMATION

Last Name First Name M.I.

Mailing Address City State Zip

Date of Birth Sex M F Soc. Sec. # Marital Status S M W D

Hm Ph # Wk Ph # Cell Ph. #

Primary Language Race Ethnicity

This data may be used by healthcare providers and government agencies for benchmarking and other quality improvement measures. Responses are voluntary.

Patient Email Address

(We do not sell or advertise personal information) How do you prefer to be contacted for reminders? ❑ Phone ❑ Postal Mail ❑ E-mail

Spouse or Partner's Name Phone

Employers Name Phone

Referring Physician Name Phone

Primary Care Physician Name Phone

Pharmacy Name & Location Phone

How did you hear about us? ❑ Physician ❑ Hospital/ER ❑ Internet ❑ Newspaper ❑ Friend ❑ Television ❑ Dentist ❑ Other

INSURANCE INFORMATION (Copy of Insurance Card(s) will be made)

Primary Insurance Info

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

Secondary Insurance Info

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

EMERGENCY CONTACT INFORMATION

Name Phone # Relationship to Patient

To Protect the privacy of all Mountain Heart Patients, I will not electronically record, photograph or duplicate patient health information or identity.

MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION

OFFICE VISIT COPAYS AND DEDUCTIBLES ARE DUE AT CHECK-IN

As a courtesy to our patients, Mountain Heart will submit a claim to your insurance for you. However, this does not guarantee full coverage or non-covered services. I understand and agree that any non-covered charges incurred by me are solely my responsibility.

I hereby authorize Mountain Heart to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the service performed. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. This authorization shall continue and be in full force and effect until revoked in writing by me. I understand that deductible and copays are due at the time of service and I am ultimately responsible for payment of all charges for services rendered and any incurred collection costs (40%) by any outside agency. **We accept VISA, MASTERCARD, AMEX and DISCOVER.**

Patient Signature Date

Guardian Signature (proof of guardianship will be obtained) Date

2000 S. Thompson St., Flagstaff, AZ 86001, Ph (928) 226-6400

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Mountain Heart's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)	Name/Relationship if signed by other than patient
Signature	Date

Mountain Heart™
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Kent D. Winkler, MD, FACC
Medical Director
Robert Wolyn, MD
Vincent X Grbach MD FCCP
Robert S. Rosenberg, DO, FCCP
Megan Engbring, DNP
Elisa Hilburn, ACNP
Mackenzie R. Lurie, PA-C

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AUTHORIZATION FOR INFORMATION RELEASE

Patients/Legal Guardians:

By signing this form, you are giving our office staff permission to discuss (either by phone or in person) personal medical information with persons whom you have given permission to know your private medical history.

Name	Relationship
Name	Relationship
Name	Relationship

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

Please check one of the following Statements:

- ❑ Five Wishes
- ❑ I Have Executed an Advance Directive
- ❑ A Living Will
- ❑ Designation of a Health Care Surrogate
- ❑ Durable Power of Attorney
- ❑ I Have Not executed an Advanced Directive, a Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.

Name of Designee:

Address: _____

_____

Relationship: _____

Telephone: _____

(Please bring in a copy of any of the above documents for our records.)

Patient Signature: _____ Date: _____