Muskogee Cardiovascular Center
Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

1. I authorize ***MUSKOGEE CARDIOVASCULAR CENTER*** to:

   ☐ Use my health information as described below; and/or

   ☐ Disclose my health information to the following individual or organization:

   _____

   Address: _____

2. The purpose(s) for the use or disclosure is as follows: _____

   _____

3. The type and amount of information to be used or disclosed is as follows:
   Health information covering treatment from

   _____, _____ to _____, _____
   Date of Service Date of Service

   ☐ Abstract
   (Includes H&P, Progress notes, Procedure reports, Consult, DS, Diagnostic Testing, and all dictated reports.)
   ☐ Copy of Medical Record only
   ☐ Copy of Complete Record (medical records and financial records)
   ☐ History and Physical (H&P)
   ☐ Consultation
   ☐ Summary
   ☐ Discharge Summary (DS)
   ☐ Operative / Procedure Report (OP)
   ☐ Pathology Report
   ☐ Laboratory Report
   ☐ X-Ray Report

   Other: _____

   _____

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand that my revocation will not apply to the extent that ***MUSKOGEE CARDIOVASCULAR CENTER*** has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. ***MUSKOGEE CARDIOVASCULAR CENTER*** may not condition treatment or payment on my signing this authorization. I understand that if I authorize ***MUSKOGEE CARDIOVASCULAR CENTER*** to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Practice Administrator.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED

Muskogee Cardiovascular Center

Patient Agreement

Limitation of Practice: Patient understands that Dr. Mohamad A. Mahayni's practice is limited to Cardiology.

Patient Consent: Patient herby gives consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include AIDS testing.

Privacy Policy

All patients have a right to review our Notice of Privacy Practices. Any employee of the practice can provide you a copy of the Notice of Privacy Practices. If you would like to restrict access or request modifications be made to you Personal Health Information, please request the required form from a member of our staff.

Collection Policy

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, Muskogee Cardiovascular Center will file a claim to the patient's insurance coverage.

Assignment and Release: Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician; Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes and information released to other practitioners in good faith effort for medical care.

Medicare: Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to *Muskogee Cardiovascular Center* and their associates for any services furnished the patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Center for Medicare and Medicaid Services (CMS) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) require specialists and sub-specialists to obtain a referral number before the physician can see a patient. The patient is responsible for obtaining a referral number, not this office. Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Muskogee Cardiovascular Center

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patient visit in the form of cash or check. If a co-payment is not made at the time of the patients visit, *Muskogee Cardiovascular Center* reserves the right to require co-payment be made prior to all future patient visits.

Maximum 30-Day Period for Unpaid Balances

Patient Balances are due 30 days after insurance coverage payment has been made. In the alternative, the patient must make acceptable payment arrangements by contacting the Billing Department at *Muskogee Cardiovascular Center*. Balances may be paid via cash, check, or credit card.

Unpaid Balances

If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Office Manager at *Muskogee Cardiovascular Center* to make acceptable arrangements. *Muskogee Cardiovascular Center* reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis.

Service Charge

Muskogee Cardiovascular Center reserves the right to assess a service charge, no to exceed $20 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to patient accounts where the patient has made payment arrangements with the Billing Department and payments are being made as agreed.

Patient Signature_____Date_____
Provider Signature_____ Date_____

ALL QUESTIONS CONCERNING THESE POLICIES
SHOULD BE DIRECTED TO THE ADMINISTRATOR.

Muskogee Cardiovascular Center
3502 West Okmulgee Street Muskogee, Ok 74401

Name _____ Date _____

Muskogee Cardiovascular Center
Review of Systems

GEN
- ☐ Loss of appetite
- ☐ Increased appetite
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain

Eyes
- ☐ Double Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blurred vision
- ☐ Black curtains

ENT
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Freq. nose bleeds

Respiratory
- ☐ Frequent cough
- ☐ Cough up blood
- ☐ Sleep on many pillows
- ☐ Chest pain w/ breathing
- ☐ Wheezing

GI
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Blood in stools
- ☐ Black stools
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Difficulty swallowing

GU
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Prostate problems

Muscular
- ☐ Back pain
- ☐ Arthritis
- ☐ Gout
- ☐ Calf pain w/ walking
- ☐ Frequent falls
- ☐ Use a walker

Neurology
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling
- ☐ Frequent headaches
- ☐ Stroke
- ☐ Slurred speech
- ☐ Fainting

Endo
- ☐ Thyroid disease
- ☐ Pancreatitis
- ☐ Erectile dysfunction
- ☐ Intolerance to cold
- ☐ Intolerance to heat
- ☐ Decreased sex drive

Lymph/Hematology
- ☐ Anemia
- ☐ Easy bruising
- ☐ Lymphoma/leukemia

Psych
- ☐ Depression
- ☐ Anxiety
- ☐ Mental illness
- ☐ Poor memory
- ☐ Frequent crying

Skin
- ☐ Hives
- ☐ Swelling
- ☐ Frequent rash
- ☐ Frequent itching

Immunizations
- ☐ Flu immunization
- ☐ Pneumonia vaccine

Sleep
- ☐ Loud snoring
- ☐ Quit breathing in sleep
- ☐ Very sleepy in daytime
- ☐ Chronic fatigue
- ☐ Fall asleep frequently during daytime

Blood relatives (list) who have had:
- ☐ Heart Attack/Angina _____
- ☐ Coronary Bypass _____
- ☐ Balloon Angioplasty / Stent _____
- ☐ High blood press. _____
- ☐ High Cholesterol _____
- ☐ Heart Birth Defects _____
- ☐ Diabetes _____
- ☐ Sudden death at an early age _____
- ☐ Stroke _____
- ☐ Heart Failure _____

Habits/Personal History
- ☐ Smoke- pk/day _____
- ☐ Quit smoking when _____
- ☐ Years smoked _____
- ☐ How much did you smoke previously? _____ pk/day
- ☐ Chew tobacco
- ☐ Coffee cups/day _____
- ☐ Tea/soda #/day_____
- ☐ Drink alcohol how much? _____ how often? _____

Social History
- ☐ Live at home/other _____
- ☐ M / S / D / W
- ☐ Biological children _____
- ☐ Work / Retired / Disabled / Other

Do/Did you ever have:
- ☐ Abdominal aneurysm
- ☐ Diabetes mellitus
- ☐ High cholesterol
- ☐ Stroke
- ☐ Cancer
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Angina
- ☐ Angioplasty- balloon stent
- ☐ Bypass surgery
- ☐ Valve replacement
- ☐ Varicose veins
- ☐ Sleep apnea
- ☐ Use CPAP/BiPAP
- ☐ Atrial fibrillation
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Pneumonia
- ☐ Blood clots in the legs
- ☐ Blood clots in the lungs

List all allergies:

_____
_____
_____
_____
_____

Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ All Reviewed, Mohamad A. Mahayni, MD