FLOW HEART & VASCULAR

Nachiket J. Patel, MD, FACC, FSCAI
Interventional Cardiology
Coronary & Peripheral Vascular Interventions
107 N Greenfield Rd, Suite 1
Mesa, AZ 85205
Phone: (480) 571-1863 | Fax: (480) 571-0269

NEW PATIENT INTAKE

Patient Information

_____ _____
Full Legal Name Date of Birth (MM/DD/YYYY)

_____ _____
Phone Number E-mail Address

Emergency Contact Information

_____ _____ _____
Name Phone Number Relationship

HIPAA Acknowledgement

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Flow Heart & Vascular. This notice explains how my protected health information may be used and disclosed for purposes of treatment, payment, and healthcare operations, as well as other uses permitted or required by law. I understand that I may review the Notice of Privacy Practices and request a copy at any time. I understand that I may request restrictions on certain uses or disclosures of my information, though the practice is not required to agree to all requested restrictions. Information disclosed as permitted by law may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

_____ _____
Patient/Representative Signature **Date** (MM/DD/YYYY)

Consent for Treatment

I consent to receive medical evaluation and treatment from Flow Heart & Vascular and its physicians, providers, and staff. This may include examinations, diagnostic testing, and other services necessary for my care. I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of my treatment. I understand that I may ask questions about my care at any time. I may refuse or withdraw consent for treatment at any time.

_____ _____
Patient/Representative Signature **Date** (MM/DD/YYYY)

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____
Full Legal Name Date of Birth (MM/DD/YYYY)

I authorize Flow Heart & Vascular, LLC and its physicians, staff, and affiliated providers to disclose my protected health information (PHI) to the individuals listed below. This authorization allows these individuals to receive information regarding my medical care, including but not limited to:

- Medical conditions and diagnoses
- Test results (labs, imaging, cardiac testing, etc.)
- Treatment plans and medications
- Appointment scheduling and care coordination
- Billing or insurance matters related to my care

By signing this form, I understand that I may revoke this authorization in writing at any time by contacting the provider above. Revocation will not apply to information already released based on this authorization. Your treatment, payment, enrollment, or eligibility for benefits will not be affected. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Authorized Individuals:

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

_____
Patient/Representative Printed Name

_____ _____

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MEDICAL HISTORY

Tobacco Use	Alcohol Use	Exercise Activity	Exercise Frequency
☐ Current	☐ Never	☐ Light (walking, stretching)	☐ Never
☐ Former	☐ Socially/Occationally	☐ Moderate (hiking, cycling)	☐ 1-3 Times/Week
☐ Never	☐ Weekly	☐ Vigorous (running, sports)	☐ 4+ Times/Week
	☐ Daily	☐ N/A	

Recent Hospital Visits in the Past 6 Months (Select all that Apply)

☐ Visited the Emergency Room
☐ Been Admitted to the Hospital
☐ Undergone Surgery
☐ None of the Above

If applicable, please briefly write the details of the visit.

_____

_____

Is there any history of cardiovascular related health issues in your family? If so, please list below.

_____

_____

Reason for Visit / Current Concerns

_____

_____

_____ _____

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