www.amscardiology.com 215.517.1000

Cardiovascular Health Questionnaire

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Occupation: _____

Primary Care Physician: _____

Smoking History: _____

Drug Allergies (Please list medications and symptoms caused):

_____

_____

_____

Medications and Supplements
Please list all current medications, vitamins, and supplements:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Continued on next page

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Surgical History
Please list any surgeries you've had and the dates:

- _____
- _____
- _____
- _____

Family Heart Health History

Family Member	Living	Deceased	Cause of Death	Known Illnesses
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Brother(s)	☐	☐	_____	_____
Sister(s)	☐	☐	_____	_____

Your Health Symptoms

Please check if you have experienced any of the following:

Symptom/Condition	Yes	No	If Yes, for How Long?
Chest Pain (at rest or during exercise)	☐	☐	_____
Shortness of Breath	☐	☐	_____
Diabetes (high or abnormal blood sugar)	☐	☐	_____
High or Abnormal Blood Pressure	☐	☐	_____
Swelling of Legs or Feet	☐	☐	_____
Pain in the Calves when Walking	☐	☐	_____

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Heart Murmur	☐	☐	_____
History of Rheumatic Fever	☐	☐	_____
Palpitations (irregular or rapid heartbeat)	☐	☐	_____
Fainting or Black-out Episodes	☐	☐	_____
History of Heart Attack	☐	☐	_____
Abnormal EKG	☐	☐	_____
Lung Disease	☐	☐	_____
Bleeding Disorder or Internal Bleeding	☐	☐	_____

Implanted Heart Devices

Do you have an ICD, pacemaker, or defibrillator?

If yes, please indicate the device brand:

_____

Tell Us More

What health issue bothers you the most right now?
(Use the space below or the back of this form if needed.)

_____

_____

_____

_____

Thank you for trusting us with your heart health!

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize my health care provider (Name)_____
To release my health care information to:
AMS Cardiology Attn: Dr. _____
118 Welsh Road
Unit B
Horsham, PA 19044
Fax#: 215-376-1705

I authorize the release of the following health information:
___Office notes, hospital summaries, test results
___Communication from other physicians/consultants
___List any specific items to be sent that are not covered above:
I understand that I may revoke this authorization/consent (except to the extent that action has been taken in reliance therein) at any time by written, dated communication.

Patient Signature:_____

Date:_____

If the patient is unable to give consent because he/she is a minor or has a physical/mental condition, please complete the following required information:

Guardian Signature:_____ Date:_____

I hereby designate_____ to claim my records on my behalf

AMS Cardiology Locations

Main Office: 118 Welsh Road, Unit B Horsham PA 19044
Montgomeryville Office: 1010 Horsham Road Suite 214 North Wales PA 19454
Horsham Office, Imaging, Rehab: 507 Prudential Road Suite 101B Horsham PA 19044
AMS Cardiovascular ASC: 507 Prudential Road Suite 101A Horsham PA 1900

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Financial Policy

Thank you for choosing Abington Medical Specialists (AMS) as your healthcare provider.
We are committed to delivering the highest quality of care. Please take a moment to review and sign our financial policy. If you have any questions, our staff will be happy to discuss the policy or any fees with you. As the responsible party, please understand the following:

1. **Insurance Billing**: AMS will submit claims to your insurance company on your behalf. However, you are ultimately responsible for any outstanding balance. Please inform us of any issues so we can assist you.
2. **Patient Responsibility:** You are financially responsible for any portion of the bill not covered by your insurance carrier.
3. **Payment at Time of Service:** Co-payments, co-insurance, and deductibles are due at the time of your visit. We are contractually obligated to collect these fees and cannot waive them.
4. **Surgical/Procedure Payments:** Your financial portion of any scheduled procedure must be paid before the procedure date. AMS will provide an estimate of your responsibility and a due date for payment. We are happy to work with you to create a feasible payment plan if needed.
5. **Updated Information:** Please notify our staff of any changes to your address, phone number, or insurance coverage.
6. **Referrals**: If your insurance plan requires a referral, it is your responsibility to obtain one. If a visit is denied due to lack of referral, you agree to pay AMS in full for the services provided.
7. **Collections**: Accounts with unpaid balances may be referred to a collection agency. You will be responsible for any applicable collection or legal fees.
8. **Returned Checks:** If a check is returned, you will be charged a $25.00 bank fee in addition to the amount of the check. All future payments must be made by cash, money order, or credit card.
9. **Form Completion Fees:** Insurance companies do not reimburse for the completion of disability or FMLA forms. You are responsible for a $25.00 fee per form submitted to AMS.
10. **Missed Appointments:** As a courtesy, AMS places confirmation calls 48–72 hours prior to your appointment. If you need to cancel or reschedule, please do so at least 24 hours in advance. **A $75.00 fee will apply to new patients or scheduled testing/procedure who miss an appointment or cancel without sufficient notice. Established patients may be charged a $25.00 fee for missed appointments.**

Abington Medical Specialists is authorized to release to my insurance company(s) any necessary information needed to file and expedite payment of my claims. Assignment of any benefits should be payable on my behalf to Abington Medical Specialists.

_____ _____

Print Name *Date of Birth*

_____ _____

Signature of Patient or Legal Representative *Date*

Notice Regarding Legal Venue for Disputes

To ensure fairness and continuity of care, AMS Cardiology requests that any legal claims or civil actions related to your treatment be filed only in Montgomery County, Pennsylvania, where the care was provided and where our practice operates.

This request is in response to recent changes by the Pennsylvania Supreme Court that may increase legal and insurance burdens on healthcare providers. Litigating outside Montgomery County could disrupt patient care and impose undue hardship on you and our practice.

By signing below, you agree that any legal action related to care received from AMS Cardiology or its staff will be filed exclusively in Montgomery County, and if necessary, resolved in Montgomery County courts.

We remain committed to providing excellent care and welcome any questions you may have.

Patient Acknowledgment and Signature

I, the undersigned patient, acknowledge although Pennsylvania law may permit filing lawsuits or legal action in other places, that I have read and understood the above notice regarding the legal venue for disputes. I agree that any lawsuit or legal action which is in any way related to healthcare I receive from AMS Cardiology and/or its agents/ employees must be filed exclusively in Montgomery County, Pennsylvania.

Signature of Patient: _____

Printed Name: _____
Date: _____

Authorized Representative Acknowledgment and Signature

I, the undersigned authorized representative, acknowledge that I have read and understood the above notice regarding the legal venue for disputes on behalf of the patient. I agree that any lawsuit or legal action related to healthcare received from AMS Cardiology and/or its agents/employees must be filed exclusively in Montgomery County, Pennsylvania.

Signature of Authorized Representative: _____

Printed Name: _____
Date: _____
Relationship to Patient: _____

HIPAA Acknowledgement Form

Patient Name: _____
Date of Birth: _____

This acknowledgement confirms that I have received and reviewed the Notice of Privacy Practices provided by AMS Cardiology which outlines how my health information may be used and disclosed, and how I can access this information.

I understand that:

- The Notice of Privacy Practices may be amended at any time.
- I may request a copy of the current notice at any time.
- I have the right to request restrictions on how my health information is used or disclosed.

I acknowledge receipt of or have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Representative:

Date: _____

Printed Name of Legal Representative (if applicable):

Relationship to Patient:
