Southeastern Cardiology Associates, P.C.

Shane B. Darrah, M.D.
Jed Vickers, P.A.-C0020
2300 Manchester Expressway, H-104
Columbus, GA 31904
Phone: 706-243-4500 Fax 706-243-4503

TO ALL PATIENTS: Your kindness in furnishing information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Date: ______________________ Circle one: Dr. Darrah Male____ Female _____

Patient Name: ____ Age: ______________
Last First MI

Date of Birth: ________/________/__________ Social Sec. Number: _______-______-_____________

Address: ____
Street City State Zip

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

Employed by: ____ Occupation : _______________________________

Martial Status: M S W D Spouse's Name: ____

Next of Kin: (Other than spouse) ____
In case of an emergency

Relationship: _________________________________ Phone: _________________________

Referring Doctor: _________________________ **City,State:** _______________________ **Tele#**______________________
Primary Doctor: __________________________ **City,State:** _______________________ **Tele#**______________________

Name of person assuming responsibility for these charges: ____

INSURANCE INFORMATION

Please provide the receptionist with all your insurance cards and your driver's liscense.

Primary Insurance ________________________________ Policy #: ___________________Group #___________________

If your insurance is through your spouse, please provide the following information.

Spouse's name: __________________________________ **Social Sec. #**______________________________

Spouse's Employer: ___________________________ **Spouse's Date of Birth:** _________________________

Please list your secondary medical insurance, if any.

Insurance ___________________________________ Policy #: ______________________Group #___________________

Insurance ___________________________________ Policy #: ______________________Group #___________________

You herewith give permission to Southeastern Cardiology Associates now and hereafter to submit full medical reports, within discretion, to your accident, health insurance companies, or our agents, if they so request. I specifically assume and guarantee responsibility for all charges relating to the above named patients account.

Please sign here: ____

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NOTICE OF HIPPA POLICIES AND PATIENT ACKNOWLEDGEMENT FORM

I ACKNOWLEDGE THAT Southeastern Cardiology Associates follows the guidelines set forth by the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

HIPPA assures health insurance portability by eliminating job lock due to pre-existing medical conditions and reduces healthcare fraud and abuse, while enforcing standards for health information by guaranteeing the security and privacy of your health information.

I understand that the practice may use my personal health information to help provide health care to me with regard to billing and payment and/or other health care options. There may be no other uses or disclosures of this information unless I permit. I do, however, understand that sometimes the law may require the release of this information without my permission. I also understand that my health information is private and confidential. I understand that Southeastern Cardiology Associates will strive to protect my privacy and preserve the confidentiality of my personal health information.

I understand that Southeastern Cardiology Associates has established procedures that help them in protecting my personal health information. These procedures may include other signature requirements, written acknowledgement, authorizations, and reasonable time allowance for requested information. I understand there may be charges incurred for copying my health information and for non-routine information needs.

I further understand that Southeastern Cardiology Associates will not use or disclose my health information without my authorization, except as described in this notice. I understand that Southeastern Cardiology Assocciates will also discontinue to use or disclose my health information after receiving a written revocation of the authorization according to the procedures included in the authorization.

My signature below indicates that I understand and agree with the above use of my protected health information and that I have received a copy of th HIPPA Privacy Rule.

______________________________ __________ __________
Patient or legally authorized signature Date Time

____
Relationship if other than patient

____
Witness

MESSAGE AUTHORIZATION Patient Name: ______________________________

Southeastern Cardiology Associates considers patient confidentiality to be of the upmost importance and concern. In an effort to ensure that your privacy is protected, please read and sign the following consent form.

FOR AUTHORIZATION

I authorize the Southeastern Cardiology Associates to leave a message at my **home** answering machine pertaining to the following (check all that apply):

___ Date and time of upcoming appointment
___ Laboratory results (e.g., blood tests)
___ Xray, CT scan, MRI or other radiological results
___ Reminder to schedule recurring screening services or testing (e.g., protimes or annual checkups)
___ Referral information (appointment with another health provider)
___ Other (Please list) ____

I authorize Southeastern Cardiology Associates to leave a message on my **work** voicemail or answering machine pertaining to the following (check all that apply)

___ Date and time of upcoming appointment
___ Laboratory results (e.g. blood test)
___ Xray, CT scan, MRI or other radiological results
___ Reminder to schedule recurring screening services or testing (e.g., protimes or annual checkups)
___ Referral information (appointment with another health provider)
___ Other (Please list) ____

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my telephone messaging system.

Signed: ______________________________ Date: _____/_____/_____

FOR NO AUTHORIZATION

___ I do not authorize any messages related to my health care to be left on my home answering machine.
___ I do not authorize any messages related to my health care to be left on my work answering machine.

Signed: ______________________________ Date: _____/_____/_____

AUTHORIZATION REVOKED

Message authorization revoked on _____/_____/_____

Initials of individual receiving written revocation _____/_____/_____

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Dr. B. Darrah, M.D.
Vaihav V. Patel, M.D.

We use Physicians Assistant, Jed Vickers, PA-C, in our office for those levels of practice that have been approved by the Georgia State Board of Medical Examiners.

Your signature on this approval form conveys that you are in agreement with being treated by out Physician Assistants whom act under our supervision.

______________________________ ______________________
Patient Signature Date

______________________________ ______________________
Witness Signature Date

Southeastern Cardiology Associates, P.C.
Shane B Darrah, M.D.
Jed Vickers, P.A. -C.

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

IMPORTANT: Do not sign this form without reading and understanding its contents. Mark out and initial any Procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types, diagnostic, or treatment procedures may be necessary. These procedures are performed by the physician or an assistant for the physician.
While usually performed without incident, there are potential risks associated with each of these procedures. It is not possible to list every risk for every procedure and this form will therefore list the most common possible risks. It is important to note that a simple act as taking a commonly used medication can rarely cause severe reactions that could lead to organ failure or even death.
If I have any questions or concerns regarding these procedures, I will ask my physician or his/her assistant to provide me with additional information. These procedures include:

- Needle sticks such as shots, injections, or intravenous lines to administer fluids or medications. Material risks include, but are not limited to infection, infiltration (fluid from an IV leaking into tissue), disfiguring scar, nerve damage with possible loss of limb function. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- Physical tests, assessments and treatments such as internal body examinations, wound cleaning and wound dressing. Material risks include allergic reaction and infection. Apart from using modified procedure and/or refusal of treatment, no practical alternative exists.
- Drawing blood or bodily fluids with a needle or taking tissue samples (biopsy). Material risks include but are not limited to infection, damage to joint or organ, nerve damage, and bleeding.
- Administration of medication whether orally, rectally, topically, or through the eye, ear, or nose. Material risks include, but are not limited to, allergic reaction, puncture, and perforation. Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.
- Insertion of internal tubes such as scopes, catheters, drainage tubes, etc. Material risks include but are not limited to internal injuries, bleeding, infection, and difficulty urinating after long term catheter placement. Apart from external collection devices or refusal of treatment, no practical alternative exists.

I understand that:

- The practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any procedures; and
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures, therefore, I agree to provide accurate and complete information about my medical history
- I may be asked to sign additional required informed consent documents for specific procedures and tests. By signing this form:
- I consent to Healthcare Professional performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen and not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed, in general terms, of the nature and purpose, the material risks and the practical alternatives of the procedures.

Signature of Patient (or other person authorized to sign): ______________________________

Printed Name: ______________________________ Date: ____________________

Reason patient unable to sign: ______________________________

SOUTHEASTERN CARDIOLOGY INITIAL WORKUP

Name: ______________________________

Date of Visit: __________ Date of Birth: ______________ Age: ____________

Please list all of the physicians who take care of you..

Physician: ____________________ Specialty: ____________________
Contact Number: ______________ City, State of Doctor: ____________________
Physician: ____________________ Specialty: ____________________
Contact Number: ______________ City, State of Doctor: ____________________
Physician: ____________________ Specialty: ____________________
Contact Number: ______________ City, State of Doctor: ____________________
Physician: ____________________ Specialty: ____________________
Contact Number: ______________ City, State of Doctor: ____________________
Physician: ____________________ Specialty: ____________________
Contact Number: ______________ City, State of Doctor: ____________________

Who is accompanying patient and relationship? ____________________
Reason for visit: ______________________________
What medical problems do you have? ____________________

What surgeries have you had and when? ____________________

Please list your allergies to food and/or medications and your reactions. __________

Social History:

1. Do you smoke? Y_____ No _____
2. How many years have for smoked? _______
3. How many packs a day on average do/did you smoke? _____
4. When did you quit smoking? __________
5. Do you use any recreational drugs? Y_____ No _____
6. How much alcohol do you drink in a week on average? (what do you drink?) __________
7. What kind of work do/did you do? ____________________
8. List any other interesting/important social information. __________

Family History:

Tell us about your parents, brothers, sister, and/or children.

a. Who had heart disease at a young age? ____________________
b. At what age did they develop heart disease? ____________________

Has anyone had a heart attack, bypass, or stent placement before age 55 (men) or before age 60 (women) Y___ No ____

Do you have heart disease that you know of? Y_____ No _____

c. Tell us everything that you know about it including what you have done (like stent or bypass) when and where. ____________________

Symptoms:

Have you had any type of chest discomfort lately? Y_____ No _____

d. When did it begin? ______________________________

e. How often does it occur? ______________________________

f. What brings it on? ______________________________

g. What relieves the discomfort? Rest, nitro, etc. ______________________________

h. Does it spread anywhere? Arm, neck, back? ______________________________

i. How long does it last? ______________________________

j. Do you have any other symptoms that come on with the discomfort? Shortness of breath, nausea, chills, sweating, or other symptoms?

k. What does the discomfort feel like? ______________________________

Do you have shortness of breath? Y_____ No _____

l. Is this new? Y_____ No _____

m. How long has it been going on? ______________________________

n. What triggers the shortness of breath? ______________________________

o. Is the shortness of breath abnormal for you? Y_____ No _____

p. Does this wake you up at night? Y_____ No _____

What do you do when it wakes you up? ______________________________

Do you have strange feelings in your chest like fluttering, skipped beats, and/or fast heart beats?

Y_____ No _____

q. How often does this occur? ______________________________

r. How long has this been going on? ______________________________

Have you ever fainted? Y_____ No _____

What is your level of physical activity?

s. Do you exercise regularly? Y_____ No _____

What kind of exercise and how often? ______________________________

t. Could you climb two flights of stairs? Y_____ No _____

u. How far can you walk on level ground without having to stop? ______________________________

Please list you current medications and dosages

DRUG	DOSAGE	FREQUENCY

FOR OUR OFFICE: Physical Exam

BP Right arm _________ Left arm _________ Pulse _________

SUPRINE BP_____/_____ Pulse: _________

Standing BP_____/_____ Pulse: _________

Respiration _______ Weight KG: _______ Lbs._______

____

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____